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**Social capital, participation and the perpetuation of health inequalities:
Obstacles to African-Caribbean participation in 'partnerships' to
improve mental health**

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**Social capital, participation and the perpetuation of health inequalities:
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Objectives: There has recently been much emphasis on the role of 'partnerships' between local community 'stakeholders' in strategies to redress health inequalities. This paper examines obstacles to participation in such partnerships by African-Caribbean lay people in local initiatives to improve mental health in a town in southern England. We present a 'social psychology of participation' which we use to interpret our data. Our work seeks to illustrate some of the micro-social mechanisms through which social inequalities are perpetuated, using Bourdieu's conceptualisation of the role played by various forms of capital (economic, social, cultural and symbolic) in perpetuating social inequalities.

Design: Our empirical research consists of a qualitative case study of attitudes to participation in mental health-related partnerships in a deprived community. In-depth interviews and focus groups were conducted with 30 local community 'stakeholders', drawn from the statutory, voluntary, user and lay sectors.

Results: While interviewees expressed enthusiasm about the principles of participation, severe obstacles to its effective implementation were evident. These included severe distrust between statutory and community sectors, and reported disillusionment and disempowerment within the African-Caribbean community, as well as low levels of community capacity. Moreover, divergent understandings of the meaning of 'partnership' suggested that it would be difficult to satisfy both community and statutory sectors at once.

Conclusions: We suggest that disadvantaged and socially excluded communities are often deprived of the social resources which would provide a solid basis for their participation in partnerships with state health services. In the absence of efforts to remove such obstacles, and to generate the necessary resources for participation, partnerships may be 'set up to fail', leaving social inequalities to prevail.

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Introduction

Participation and the representation of members of socially excluded groups in health service design and delivery currently comprise key pillars of academic and government recommendations in the effort to reduce health inequalities in the UK. In the interest of maximising the potential of such participatory initiatives, our research focuses on the obstacles to effective grassroots participation and partnership by minority ethnic groups. We seek to promote realistic approaches to participation, which anticipate problems and set in place structures to deal with those obstacles. In this paper, we begin to problematise participation as a means of eliminating health inequalities through the lens of Bourdieu's (1986) discussion of forms of capital. Conceptually, we seek to contribute to efforts to understand the micro-social mechanisms through which social inequalities are perpetuated, suggesting that attempts to establish participatory structures in a situation of low or unequal levels of social capital have the potential to widen rather than to narrow health inequalities. In what follows, we first outline the proposed role of participation in redressing health inequalities in the UK. We then outline a 'social psychology of participation', focusing on the role of social capital. The substantive

context of African-Caribbean mental health inequalities in the UK is then discussed, before the presentation of our empirical findings.

The role of participation in addressing health inequalities

Community participation as a strategy to reduce health inequalities currently comprises a key principle of UK health policy (Department of Health 1999a; 1999b; Social Exclusion Unit 2000). Three forms of participation can be distinguished, each operating to improve health by a different mechanism. Firstly, partnerships between grassroots community organisations and health services are recommended as a route to eliminating sources of inequalities which might exist in the design and delivery of services. Such partnerships are expected to reduce problems of institutional racism or cultural incompetence, ensuring that services are culturally appropriate, perceived as relevant and effective, and accessible (Department of Health 1999a). Local minority ethnic community groups, voluntary groups and faith organisations are proposed as fruitful partners with statutory services in the effort to reduce any contribution that the structure of health services might be making to ethnic health inequalities (Social Exclusion Unit 2000).

Secondly, it is argued that local people should participate in community-based public health projects designed to promote healthy behaviours. This argument is based on the assumption that it is local people who are best placed to raise awareness among their peers of health issues and available services, and to encourage timely and appropriate

accessing of services. Naturally occurring, interpersonal networks serve as informal channels of health promotion and referral to services, and if members of such networks participate in community health projects, they will pass on their health-enhancing knowledge and attitudes to their peers. Furthermore, grassroots participation in local health projects may also increase people's sense of perceived self-efficacy or empowerment, increasing the likelihood that people will feel that they individually, and their community collectively, have control over health-related issues.

Thirdly, increasing attention is being given to the (indirect) relationship between participation in local community networks and groupings, and better health (Yen and Syme 1999; Veenstra and Lomas 1999). It is proposed that high levels of social capital (particularly involvement in local community groupings) reduce the likelihood of health-damaging social anxiety and increase levels of health-enhancing social support and perceived self-efficacy (Wilkinson 1999; Yen and Syme 1999; Campbell 2000). Thus, participation in a variety of community groupings, not only those directly related to health, is being advocated as an indirect means of improving community health (Department of Health 1999a; 1999b).

While we do not seek to dispute that these three forms of participation have the potential to contribute to reducing health inequalities, in this paper we argue that participation should not be considered as a unitary or isolated social process. Participation is constrained by its enactment in particular community contexts, which may introduce a variety of obstacles to its successful operation. For example, a number of research studies

in other countries have shown that participation in such local groupings, networks and partnerships is most likely to take place amongst the most privileged members of society (Baum *et al.* 2000). As such, it has been argued that measures to increase local community participation could have the unintended consequence of increasing social inequalities rather than reducing them. If factors promoting and hindering successful participation are not recognised and dealt with in policy recommendations, not only will the effectiveness of participation be reduced, but the process may even perpetuate the very inequalities it seeks to redress.

In this paper, we address the role of inequalities of social capital, as one such factor influencing the likelihood of community members engaging in participation, constraining the form which that participation may take, and ultimately, shaping its outcome. Levels of social capital comprise part of the community context into which participatory structures are introduced. Not only might social capital be generated in participation (as in the third form of participation described above), but it may also be seen to serve as a resource upon which participation can be based: as a precursor to participation. The next section elaborates the conceptual role of social capital in a 'social psychology of participation'.

The social psychology of participation

Our research draws on the concepts of social capital, social identity and social representations as conceptual tools for the development of a 'social psychology of

participation' (Campbell and Jovchelovitch 2000), which accounts for the social psychological processes shaping the functioning of community participation.

Social capital

The relationship of high levels of social capital both to better health and to increased political participation have attracted much attention in recent years. While the concept of social capital has been variously defined by a number of theorists (Portes 1998; Schuller *et al.* 2000), it is Putnam's (1993) definition which has captured the most attention in the health field. Putnam defined social capital in terms of both networks (high levels of participation in local community groupings) and norms (high levels of trust and reciprocity amongst community members). Two forms of social capital are distinguished in Putnam's later analysis: 'bonding' and 'bridging' social capital (Putnam 2000; Gittel and Vidal, 1998). Bonding social capital refers to intra-community ties among people with similar goals and interests, and bridging social capital refers to ties across social groups, such as ties between communities and public services.

In a micro-qualitative study investigating the suitability of Putnam's (1993) concept of social capital as a tool for conceptualising local community life in England, Campbell, Wood and Kelly (1999) argue that, while social capital provides a useful starting point, much work remains to be done in tailoring it to apply to local conditions and participation in specific local services. In particular they point to an urgent need to examine the way in which forms of social exclusion such as poverty and ethnicity shape

and constrain the existence of social capital. On this view, social capital and participation must be conceptualised as embedded in community and macro-social contexts whose unequal structure impacts upon the potential for participation by differing societal groups, and it is this perspective that informs the research presented in this paper.

Some writers have sought to polarise social capital and poverty as competing explanations of health inequalities, rather than seeing them as complementary (Muntaner *et al.* 2001). Unsurprisingly, a range of epidemiological studies have found that material living conditions and socio-economic position are stronger predictors of poor health than various indicators of social capital (Cooper *et al.* 2000). Radical critics of the concept have used such findings as an attempt to discredit it, arguing that the current emphasis on social capital is part of a political agenda to mask the effects of poverty on ill-health and to justify reduced welfare spending (Labonte 1999; Muntaner *et al.* 2001). In contrast to such polarisation of social capital and poverty as competing explanations for health inequalities, Gillies, Tolley and Wostenholme (1996) emphasise their complementarity. They argue that the primary cause of health inequalities is poverty, and that the economic regeneration of deprived communities is essential for reducing such inequalities.

However, they qualify this claim with their argument that since one of the effects of poverty is to undermine community networks and relationships, economic regeneration must be accompanied by social regeneration (i.e. projects to enhance social capital) if they are to have optimal success in improving health. Along these lines, others argue that a focus on social capital could contribute to much-needed research into the mediating mechanisms whereby various forms of material and symbolic social exclusion impact on

health (Baum *et al.* 2000). The work of Bourdieu (1986), with his emphasis on the role played by different forms of capital in the reproduction of social inequalities is often cited as a potentially useful starting point for a critical conceptualisation of social capital, in which social and economic capital are fundamentally inter-linked.

According to Bourdieu, social inequalities should be understood in terms of the unequal distribution of four inter-connected forms of 'capital' within a society: economic capital, symbolic capital, cultural capital and social capital. Economic capital is the basic form of capital, comprised of material possessions, money and property. Cultural capital includes the set of social practices and skills which are slowly cultivated during a person's development, and demonstrate his or her membership of a particular social grouping or class. Cultural capital may be institutionalised in the form of academic qualifications. Symbolic capital can be said to be held by a person whose voice is recognised as legitimate, one whose assertions are to be taken seriously. Finally, social capital is comprised of the resources that derive from group membership, that is, from participation in a network of mutually-supportive relationships.

By using the term 'capital' (instead of, for example, 'power'), Bourdieu emphasises that the different forms of capital, while not reducible to economic capital, share some of its properties. A key such property is the tendency of capital to accumulate, and thereby, for the relative distribution of capital in a society to be highly resistant to change. Possession of a certain amount of capital facilitates further generation of capital. Thus, for example, the greater the stocks of economic, cultural and symbolic capital among those people

who comprise one's base of social capital, the more valuable that social capital.

Moreover, high levels of social capital (such as business contacts) greatly facilitate one's development of economic capital. On the other hand, economic capital can be put to use to generate social capital (such as funding networking events). It is this self-reinforcing, or 'multiplier effect' of possession of capital, combined with the inter-convertability of the forms of capital, that enforce the perpetuation of social inequalities. Thus, Bourdieu provides us with an approach to understanding health inequalities in which the forms of capital are not seen as providing competing explanations, but rather, in which their very interdependency and inter-convertibility are sources of the perpetuation of those inequalities.

If initial inequalities in social capital affect the propensity of a socially excluded group to become involved in participation, and the use that can be made of that participation, then establishing participatory structures without addressing such initial inequalities may work to perpetuate inequalities rather than to reduce them. Attention to such processes may contribute to understandings of some of the micro-social mechanisms whereby social inequalities are perpetuated. To conceptualise social capital, we draw on Bourdieu's view of social capital as comprised of social relationships which may be drawn upon to advance a social group's interests, and on Putnam's distinction between intra-group ties ('bonding' social capital), and inter-group linkages ('bridging' social capital).

Social identities and social representations

Alongside social capital, we employ the two key concepts of social identity and social representations in our 'social psychology of participation'. Social representations are the systems of shared social knowledge which enable a group of people to make sense of their social world and to communicate about it (Moscovici 1988). Social representations and social identities are intimately intertwined insofar as our social identities are constructed out of the symbolic content provided by our own and others' representations of our claimed group memberships (Jovchelovitch and Gervais 1999). Such representational content is shaped by unequal power relations, in that dominant groups have greater power to define the representational content available for their own and others' social identities (Jovchelovitch 1997). For example, a dominant social representation of the locality of Brixton in South London, as black, dangerous, associated with drug crime, gun crime and riots, affects the social identities of young people from Brixton, who both draw on this stigmatising representation in developing a community identity, and strive to assert more positive representations of Brixton, based on a positive valuing of their multiculturalism (Howarth, 2002). In participatory partnerships, people are expected to take part on the basis of their group membership. Their participation may thus be structured by the social representations held by themselves and others of the group, that is, their social identity.

Social identity may be considered to provide resources on which participation may be built, with different identity content providing differential likelihood of a social group entering into a participatory process. We draw on Leonard's (1984) work for our understanding of the operation of identity in this context. According to Leonard, social identities are constructed and reconstructed within a range of material and symbolic constraints which often place limits on the extent to which people are able to construct images of themselves and their claimed group memberships that fully reflect their potentialities and interests. The 'institutional racism' (MacPherson 1999) which characterises English society presents a number of constraints of this nature, both in the form of higher levels of poverty (material exclusion), and lower levels of social respect and recognition (symbolic exclusion). However, Leonard argues that at particular historical moments, often through participation in collective projects and networks, members of socially excluded groupings may work together to construct identities that challenge their marginalised status. In some circumstances, participation may take the form of participation in collective networks which serve either directly or indirectly to improve people's material life circumstances, or to raise the group's levels of perceived empowerment and of the social recognition they receive from other groups. Within such a context, social identities and participation have the potential to serve as important mechanisms for social change. The specific site for social change which we address in this study concerns efforts to redress African-Caribbean mental health inequalities in the UK, as detailed in the following section.

African-Caribbean mental health inequalities and participation

Our interest in participation takes place in the context of the current policy advocacy of participation as a means of addressing health inequalities in the UK. Minority ethnic status comprises one social axis along which such inequalities are evident, with African-Caribbean, Pakistani and Bangladeshi ethnic groups suffering the poorest health (Nazroo 1997). The role of socio-economic disadvantage as a primary cause of ethnic health inequalities is well-established, with those social groups least materially affluent also being the groups most likely to suffer poor health (Nazroo 1998). Alongside socio-economic explanations, factors such as ethnic identity and culture, non-economic forms of racial discrimination, and differential participation in local social and community networks are suggested as non-economic mechanisms contributing to health inequalities (Smaje and Le Grand 1997; Williams *et al.* 1997; Nazroo 1997; 1998; Morgan *et al.* 2004). The key concerns of the literature on African-Caribbean mental health inequalities are the relatively high levels of schizophrenia diagnosis and of involuntary admission under the 1983 Mental Health Act (Littlewood 1986; Dunn and Fahy 1990; Boast and Chesterman 1995; Davies *et al.* 1996; Lipsedge 1998; Singh *et al.* 1998). The finding that African-Caribbean people tend to under-utilise support services has been proposed as an important factor contributing to the severity of mental health problems presented when African-Caribbean people eventually reach health services (Bhui *et al.* 1995).

In a companion paper to this one (McClean *et al.* 2003), we report on the perceptions of local mental health services held by African-Caribbean people in our community of

interest. We found that social exclusion - in economic, cultural and institutional forms - structured our African-Caribbean interviewees' reported experience and expectations of health services. Low levels of awareness of the existence of support services were reported in this community, and interviewees' reported experience of services was characterised by cultural incompetence or institutional racism. These problems lead to a lack of timely and appropriate accessing of support services by potential clients, leading, in turn, to worsening mental health.

The role of cultural exclusion from services is confirmed by findings in other UK studies. Reference has been made to cultural mis-recognition of African-Caribbean modes of speech and conduct. Cultural stereotyping of African-Caribbean users of mental health services as more likely to be irrational, threatening and dangerous than their white counterparts has also been reported as contributing to the aversive experience and subsequent avoidance of mental health services by potential clients (Callan and Littlewood 1998). Such problems are also reflected in the low satisfaction rates reported by African-Caribbean communities in relation to their local mental health service provision (Bhui *et al.* 1995; Parkman *et al.* 1997). Such findings suggest that the poor relationships between African-Caribbean communities and mental health services may be one of the factors generating mental health inequalities.

Participation would appear to be a suitable means of addressing these problems, through its ability, firstly, to communicate African-Caribbean dissatisfaction with services and suggest ways of making services more culturally relevant and accessible, and secondly,

through promoting awareness of the existence of support services among community members. The potential of participatory partnerships to improve African-Caribbean mental health is supported by a study addressing the relationship between usage of mental health services and 'community level health care social capital' (Hendryx and Ahern 2001). This study reported on data from 43 cities which showed that higher levels of 'community level health care social capital' (of which partnerships amongst community groups is one important component) are associated with greater usage of mental health services. Thus, participation, as a way of bringing together health services and community members, should be an effective way of redressing the cultural exclusion from services reported by African-Caribbean communities, and thereby, of reducing mental health inequalities.

Social exclusion in a variety of forms is widely recognised as being implicated in the poorer mental health outcomes experienced by African-Caribbean communities, with participation being proposed as a means of generating greater inclusion. However, an important complexity to the relationships among social exclusion, mental health and participation arises in the potential for social exclusion to undermine participation itself. In an earlier paper we argued that, in our town of interest in South East England, a historical context of material and symbolic exclusion of the African-Caribbean community from mainstream British society had contributed to the construction of a representation of their own community as divided and powerless, a representation which is not conducive to participation (Campbell and Mclean 2002). Moreover, distrust of health services as treatment providers may well go hand-in-hand with a reluctance to

engage with such services in participatory partnerships. Thus, the same forms of exclusion implicated in mental health inequalities may also simultaneously limit the operation of participation. This case study of views on participation in mental health fora held by an African-Caribbean community seeks to examine the operation of such obstacles to participation.

Study aims

Our goals for this study are three-fold. Firstly, we seek to apply our proposed 'social psychology of participation' to a real-world community context of proposed inter-sectoral partnerships. Secondly, using Bourdieu's conceptualisation of the inter-relatedness of forms of capital, we aim to contribute to understandings of the mechanisms through which social inequalities are perpetuated. Thirdly, in the context of policy calls for partnerships to address social inequalities, we wish to call attention to obstacles to such partnerships which exist in the often disadvantaged community contexts into which partnership is introduced.

The research context

This research was commissioned by a local statutory public health body as part of an effort to improve mental health service provision for African-Caribbeans in a South England town. In this town, relationships between health services and the local

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community have been poor, with African-Caribbean users of mental health services and their advocates complaining of institutional racism, cultural incompetence and disinterest on the part of statutory health services. Strong distrust and scepticism of the statutory sector appear to have been discouraging potential clients from accessing services. In response to the perceived inadequacy of state service provision, a number of small local ethnically-specific voluntary organisations had emerged to deal with mental health issues, particularly to offer support and advocacy services to mental health service users. One of these grew out of the activities of the local church. The services received the support of the statutory sector, and tended to be highly-prized by community members, who valued a focus on issues of cultural identity, the rootedness of these organisations within the local community, and the focus on individual practical needs. Our commissioning body was interested in the potential for participation as a means of addressing the barriers to African-Caribbean accessing of health services. Hence, this research was commissioned to address local African-Caribbean perspectives on health promotion and treatment, and potential for participation.

In this context, the participatory activities of interest to us were (i) inter-sectoral partnerships and (ii) participation by grassroots lay people in community consultative fora. Such inter-sectoral partnerships sought to link together the statutory sector - that is, those parts of the council with responsibility for health - with community-based voluntary organisations in order to obtain community input on design of statutory services, and to have local organisations carry out mental health support and care work for their local community. Community consultative fora would involve inviting

community members to meetings on mental health issues, again, to ensure cultural appropriateness in service design, and to generate awareness among community members of the availability of support services, to encourage their early uptake. Some efforts had already been made by the council to establish such partnerships and consultative fora. The empirical research reported here takes the form of a qualitative case study of views on partnerships between the statutory sector and the African-Caribbean community in one particular town. We do not wish to claim that this case study is representative of the UK African-Caribbean community or of health services generally.

Research methods

Interviews and focus groups

The third author conducted semi-structured interviews and focus groups with a purposive sample of thirty individuals from, or working with, the African-Caribbean community in our town of interest. Focus groups (two) were the preferred method for interviewing mental health service users attending a weekly support group at a local community centre, in line with their perceptions that they would feel more comfortable in a peer setting. All other informants were interviewed individually. Interviews and focus groups lasted from an hour to an hour and a half, and the eight interviewees who were not employed in paid work relating to the African-Caribbean community in the town were

paid £10 consultancy fee. The African-Caribbean background of the interviewer proved to be a key resource in gaining participants' trust, in the context of a historical experience of misrepresentation or lack of attention by outsiders. Participants expected that, given the ethnicity of the interviewer, they could have confidence that he would not misinterpret or over-exaggerate their comments or represent the community in a damaging way, and thus they were willing to express criticisms both of the African-Caribbean community and of the statutory sector. We hope that our writing lives up to participants' significant trust.

Sample

Our conceptualisation of the 'African-Caribbean community' which is the target of our research includes all those who identify with the label 'African-Caribbean' and who reside in the most deprived geographical locale of our town of interest, which also has the highest proportion of minority ethnic residents. Our sample was designed to access the maximum range of attitudes and positions towards partnerships, and to cover the range of stakeholders in potential participatory processes to address mental health issues in the African-Caribbean community. Our informants were located in four categories: members of statutory organisations (including council, police and primary/secondary care workers); members of voluntary organisations (support, care and advocacy workers); mental health users and carers; and lay African-Caribbean community members. Drawing our informants from very different strata of the community was a strategy to increase the richness and reliability of our analysis, in line with Bauer and Aarts' (2000) argument for

maximising the diversity in one's sample, in order to apprehend unknown representations in their complexity. Interviewing participants from a range of very different social groupings aims to maximise the diversity of opinion, and therefore to avoid a situation of accessing only one idiosyncratic perspective confined to a particular grouping. In total, thirty individuals participated in interviews and focus groups, evenly divided among the four categories.

Topic guide

Interview and focus group topic guides sought informants' views in three main areas. Our research questions called for both positive and negative views within each of these areas, since we sought to identify both problematic areas or obstacles to effective service provision and participation; and examples of good practice, and positive elements to build upon. Our first focus was the strengths and weaknesses of existing local initiatives to promote mental health. The second was the strengths and weaknesses of existing services for the treatment of mental illness. Thirdly we sought to investigate informants' perceptions of those factors likely to promote or hinder the participation of African-Caribbean community members, and of African-Caribbean voluntary groups, in consultative fora relating to mental health issues. The first two topics are addressed in the companion paper to this one, which we have already referred to above (McClean *et al.* 2003). The current paper reports our findings on the third topic. The research was introduced to informants as being about mental health and the African-Caribbean

community. They were told that, in the course of the interview, we aimed to cover what people think about mental health in the African-Caribbean community, and what they think about the service provision now and its possibilities for the future.

Data Analysis

Interviews were audio-recorded, transcribed in full, and content analysed by a grid coding method. Each interview was analysed to pick out factors promoting and hindering participation. These factors became the names of the coding categories, with quotations and summaries filling the cells of the grid. Successive reduction of the data led to the categories which form the headings of our findings section. We first present what participation means to informants, through discussing the positive evaluation of participation, and the divergences in its interpretation. We then turn to the obstacles which exist in the relation between the statutory sector and the community, discussing community informants' perceptions that the statutory sector is not willing to change, does not trust the community, and that independence of voluntary groups would serve the community better than 'partnerships'. Obstacles within the African-Caribbean community are then outlined, in terms of alienation and disillusionment, disunity, and low community capacity. In the concluding section, we interpret these findings in terms of the theoretical issues outlined above.

Findings

While we explicitly sought, in our interview topic guide, and during the interviewing, to tap factors both facilitating and obstructing the implementation of partnerships, a general air of pessimism and scepticism pervaded our interviewees' comments about participation. Hence, far more obstacles than facilitators were revealed in our analysis, and obstacles to participation became the focus of this paper. Before we examine the obstacles, however, we should emphasise that the general principles of partnership were very widely endorsed.

Positive evaluation of the principles of partnership

Our informants were unanimous in their strong support for the ideals or principles of participation, and more particularly for the notion that local people should participate in initiatives to redress mental health inequalities. Participation was regarded as the key route to addressing the cultural incompetence and the inappropriateness of services that informants believed were the key factors preventing the timely accessing of services by African-Caribbean people with mental health difficulties. Interviewees valued the way in which the emphasis on participation in national and local government policy had highlighted the need for greater accountability by the statutory sector to local people. Lay community members welcomed the way in which participatory policies had served to highlight the need for improved transparency and greater communication between the statutory sector on the one hand, and voluntary groups and the lay community on the

other. It was within the context of such policies, that voluntary groups had made representations to the local hospital, demanding greater cultural competence in hospital services, including demands for the provision of African-Caribbean meals.

However, people's positive evaluations of the ideal of participation were continually set against criticisms of attempts to encourage such participation to date, and scepticism about the propensity and capacity of either the African-Caribbean community or the statutory sector to effectively engage in partnerships. For the remainder of our 'Findings' section we examine our informants' accounts of obstacles to effective partnerships between local grassroots people and voluntary groupings. Obstacles to successful partnership were seen to exist within both groupings of potential partners: the statutory sector and the African-Caribbean community.

Divergent versions of the meaning of participation

There was a striking disjunction in the ways in which those in power in statutory bodies and representatives of voluntary sectors understood participation, with the latter taking a far more radical view than the former. For decision-makers in the statutory sector, participatory initiatives were expected to involve a fair degree of 'business as usual', with statutory workers continuing to control the services, with the only difference being that wherever possible they would draw on information and input from lay, voluntary and user representatives. On the other hand, within the statutory sector, there were also

distinctively critical voices which argued that the statutory sector had not been willing to genuinely engage with the community, to date, and which sought to find ways to give more power to local African-Caribbean voluntary community groups. These statutory voices are among the most critical of all our informants, as may be seen in the quotes below.

For voluntary sector representatives, participation involved a very radical departure from 'business as usual'. Firstly, many believed that all health service staff dealing with the African-Caribbean community should themselves be African-Caribbean. In this regard, recent efforts to bring African-Caribbean youth into health service training were welcomed. Interviewees attributed the success of the small, ethnically-specific support service to its foundation, by African-Caribbean community members, upon extensive, organic, interpersonal linkages within the community. However they further argued that increased employment of African-Caribbean people alone would be inadequate to counter the institutional racism and the cultural incompetence of existing services for African-Caribbean people. Their confidence in the ability of existing services to make the necessary changes was so poor that they argued that it would only be when African-Caribbean voluntary sector groupings could take full responsibility for health service delivery that such problems could be overcome. While such proposals to entirely bypass the statutory sector seem unrealistic, given the important role of government bodies in issues such as funding, policy, standardisation and monitoring, we draw attention to the proposals in order to demonstrate the profound lack of confidence of community members in the ability of statutory mainstream services to adequately serve the African-

Caribbean community, and their disinclination to engage with what are seen as culturally incompetent services, incapable of change.

Arnstein (1971) refers to different degrees of participation ranging from the 'informing' and 'consultation' of citizen groups on the one hand, to the 'delegation of power' and of 'citizen control' on the other. Our data suggest that, in Arnstein's terms, voluntary sector workers held the more radical latter understanding of participation, and statutory sector decision-makers the former.

Statutory sector perceived as reluctant to change

A suspicion was expressed that participation was seen by the statutory sector as important solely for its public relations value, that community consultations held by the council would be (and had been) merely tokenistic, with no real motivation to address the key issues.

I think the only way that they would do that [establish partnerships] is if they were just trying to patronise the community and just saying 'well, we'll call in some of the black leaders'. You know, like what the police do, and they make a big issue out of it and put it on television, like 'we're trying really hard, we're paying a lot of money' (19; p15, user)¹

There was a suspicion that 'partnerships' might function solely as 'talking shops', with no concrete outcome. It was particularly felt that, if radical proposals or suggestions were

made, they would simply be ignored, so that the possibility of substantial change was ruled out from the outset.

I was a member of the [ethnic minority focused forum] until they disbanded it because they thought it was getting too powerful, so they got rid of it. That was a very useful forum because the community made a lot of very tangible, very sensible, I would say, suggestions. Some I think were taken on board but others were seen as too radical and would probably require hard decisions to be taken and I think they weren't prepared for that at that stage. (20; p2, statutory)

What they want is someone who perhaps looks like a minority representative but basically rubber stamps anything they do and say. You know, a yes-man (7; p5, statutory)

Statutory sector perceived not to trust or value the African-Caribbean community

Health services were expected by informants to be institutionally racist in their treatment of mental health service users, as a matter of course. Informants said that health service users' language and modes of self-expression are misinterpreted by culturally incompetent staff, that psychiatric diagnoses to be made too easily and that African-Caribbean service users are overly prescribed drug therapies rather than talking therapies (Mclean *et al.* 2003). Matching this perception of institutional racism, many informants were sceptical of the willingness of the council to devolve power to minority ethnic groups, suspecting that black voluntary groups were discriminated against in the allocation of funding. They felt that statutory bodies did not make sufficient effort to engage with the community.

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Talking about come and put your point of view and they're not telling us about where we can come and put our point of view about things we want doing.... They probably are holding meetings,... but it's not like they're holding meetings and telling us.... They're not telling people what's going on (16; p9, lay)

Interviewees repeatedly challenged the notion that participation by grassroots community members is expected to be unpaid, and to take place on the basis of mutual ethnic identification 'for the greater good'. The discrepancy, in that professional participants are paid, and non-professionals unpaid expressed, for many interviewees, the relative lack of valuing and appreciation of community members' input. The same conclusion was drawn from previous experience of participatory fora having been inaccessible to African-Caribbean community members due to their being held at unsuitable times and locations. Thus, issues of timing, travel and remuneration not only comprise practical barriers to participation, but the perceived lack of attention by the council to removing these barriers may generate a more profound psychosocial obstacle to participation, as confidence in the council's genuine commitment to participation is undermined. Thus, the following statutory employee placed great emphasis on the need to regain the community's confidence through being seen to be making changes.

It's about going out and talking to community leaders, talking to people in the community and saying, okay, well, what sort of service do you want? Being seen to do it and then being seen to take some action. It may only be a symbolic action at first, but you've got to start somewhere. (18; p9, statutory)

Voluntary sector values independence over partnership

Given the profound sense of distrust of the statutory sector, the relatively recent emergence of independent African-Caribbean voluntary organisations as service providers was welcomed by our informants. A view was expressed that previously, African-Caribbean health workers had been constrained in the extent to which they could raise a dissenting voice, due to their being employed by the statutory sector. The independent status of voluntary groups was seen as a vital prerequisite to an ability to express the necessary critiques of the statutory sector.

There's a voice in [town name] that's voluntary. We can say what we like. We say what we think is right. They can't touch us (2; p10, voluntary)

However, the continued reliance of voluntary groups on the statutory sector for funding was described as generating an awkward situation, in which representatives of voluntary 'partner organisations' felt inhibited from voicing their criticisms of statutory partners, for fear of putting their funding in jeopardy. In this context, where the independence of voluntary groups is so highly valued, some informants were wary about voluntary groups entering into partnerships with the statutory sector.

How much power would they really have? ... The council could say, well, you're not really working with us, you're just a little renegade group over there. Come into our group or come under our umbrella and do it that way. So, the council would like to run things, really (17; p7, lay)

Thus, a suspicion that statutory bodies would tend to dominate a partnership relationship may lead to voluntary bodies resisting such partnerships, wishing to preserve their highly-prized independence.

Alienation and disillusionment within the African-Caribbean community

Repeated experiences of social exclusion, in the context of the institutional racism of health services and British society more generally, were described as having generated an excluded and marginalised sense of identity for African-Caribbean community members that limits the likelihood that they will regard local participatory fora as potentially representative of their needs and interests. People described the community as alienated from the political process at all levels. The notion of inclusion in a democratic participatory process was seen as absurdly contradictory to African-Caribbean people's everyday experiences of political, economic, cultural and social exclusion from mainstream British life. People spoke of experiences of racist exclusion at work, at school, and in everyday interactions on the streets or in shops as the norm. They expected racist exclusion from the health services, saw no reason for confidence that proposed 'partnerships' would offer significant changes, and thus anticipated little advantage in seeking to establish community 'partnership' with health services. The response of some informants to this piece of research reflected these low expectations, as they noted that the African-Caribbean community had been consulted before but there had not been evidence of increased resourcing or provision in the context of mental health.

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I am not convinced that anything has happened in health. Nothing has changed. There are still no managers in health who have an equality or even a race focus. There is still nobody at any senior level who are saying let's look at how we deliver services to these communities. There is nobody doing it. What we have are lots of people going around, doing lots of little pieces of research that don't seem to link to anything [...] You are doing this piece of research. There have been several other pieces of research before and the community is still waiting. Where is the action out of all these pieces of research? There is no clarity as to what the purpose of the research is. What kind of outcome are we expecting, apart from a report? We've had many reports. The [Report Name] report is a very big document and it is here for all to see." (4; p10, statutory)

People referred in a general way to the historical experiences of the obstruction of African-Caribbean efforts to bring about positive change in their lives in England, which were seen to have resulted in disillusionment and low levels of perceived self-efficacy.

Interviewer: What do you think are the factors in the way that particularly African Caribbean communities may not participate in the very kind of partnerships that are being advocated at the moment?

Informant 10: Disillusionment. They've been down that road so often, if they hear it one more time, they'll just vomit on you. [Laughter] Again, the history of it didn't work. Very much communication problems as well. What I say is one thing, what you hear is another. There's lots of things like that. Lack of resources, inadequate resources, always the way. Failure to put in enough developmental time and therefore it's a vicious circle. You know, they fail because enough planning time wasn't put in, lack of capacity building, they get even more disillusioned. (10; p.8, statutory)

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Several informants were critical of a perceived apathy within their own community, while many said that people lacked the sense of collective agency that might have motivated them to feel that they had the power to bring about positive social change in their local community in general, and in their health service in particular.

The younger generation, right, everything they know is from what they see. Believe me, they're in a sorry state already. You can't motivate them because they have no belief in their own. You see it everyday. It would be much easier for a person to go and deal with a white group, and they would be quicker to join them as well, because they feel that they can deliver because they've never seen no black people deliver shit, you know. (3; p12, voluntary)

In this context, informants warned of the damaging effects of any further experiences of obstruction and failure by the African-Caribbean community to enforce change. They felt that such failure would further undermine the community's sense of agency, and further discourage them from engaging in any partnership arrangements with the council.

As a challenge to this reported alienated and disempowered identity, the work of the one ethnically-specific mental health service was particularly praised. Firstly, this service placed African-Caribbean people's mental health problems in a context of historical exclusion and racism, as a step towards challenging marginalised and excluded identities. Secondly, the staffing of this organisation by African-Caribbean community members was seen to provide encouraging role models, generating a more positive appraisal of the pro-active abilities of the local community. In contexts of excluded, disempowered identities, efforts to establish participatory structures may need to be matched by

convincing demonstrations of a genuine interest in inclusion and commitment to change on the part of the statutory sector, and efforts to generate the sense of empowerment, confidence and inclusion as a basis for participation.

Disunity in the African-Caribbean community

Again, due to particular historical experiences, interviewees described their local community as fragmented and divided. They had little confidence that African-Caribbean people would be motivated to participate in consultative fora, due to a perceived lack of black solidarity and unity in the community. They complained of a lack of the sense of mutual support and trust among African-Caribbeans that would be necessary to support high levels of participation.

We would have to get in a group. We would have to get more black people together. Its togetherness what's causing it. We're not together as we should, you know. They need more black leaders (12; p25, user)

The current degree of fragmentation was sometimes contrasted with a description of a previously cohesive community with an ethos of mutual help. Again, community development initiatives to construct supportive community linkages were called for as a prerequisite to expecting people to participate in health-related community fora.

Fragmentation of the African-Caribbean community and the expression of this fragmentation in disparate voluntary groupings in the community were also a cause of concern for members of the statutory sector, who queried the legitimacy of such small groups to speak for the African-Caribbean community as a whole. In the absence of a unified and definitive 'African-Caribbean voice', statutory representatives felt it was difficult to establish who the appropriate 'partners' might be.

*I think when the public bodies do try and engage, it's very difficult to know who to engage with.
(8; p17, statutory)*

Low community capacity – lack of 'professionalism'

The existence of a wide gap between members of the statutory sector and community members in terms of familiarity with 'professional' modes of conduct was described as a major barrier to effective partnerships. The general social, economic, and educational exclusion experienced by African-Caribbean communities, and historic under-funding of African-Caribbean organisations was seen to have led to a situation of low capacity among African-Caribbean voluntary groups. On the one hand, grassroots community members felt excluded and, to some extent, intimidated by professionals' use of language, and by formal meetings.

Professionals think they can bamboozle communities by using a lot of technical jargon and fancy medical terminology and all of this stuff and talk over people's heads (7; p11, statutory)

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You need to be a little brave to do that to the government, stand up and start talking in front of a lot of people, you know? Stage fright and all that. I wouldn't like to do it. (15; p17, user)

On the other hand, statutory members of partnerships, more familiar with 'professional' norms, may be impatient at the perceived lack of professional skills among lay African-Caribbean community members.

But again, you've got culture clashes between professionals and people. Simply, you've got someone from the community chairing the meeting. He has no idea how to chair a meeting and the professionals are getting irritated. So, you've probably had to have three meetings to come to the result that if professionals were in the chair would have achieved far more quicker. (9; p16, statutory)

It was also felt that the lack of professional skills affected African-Caribbean voluntary groups materially, as a lack of training in skills of form-filling and writing grant applications led to their submitting less professional funding applications than mainstream organisations and consequently attracting less funding.

Again, this disparity in 'professionalism' between statutory and community emphasises that, without changing the existing community dynamics, partnerships may be simply 'set up to fail' (2; p5, voluntary). Thus, as a precursor to establishing partnerships, training for community members was suggested, in order to help them to make best use of the opportunities offered by such partnership.

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Resources can release voluntary sector agencies to, for example, enable training for people who want to be trained in going to meetings and putting their views across. You can empower people, you can build their confidence and their ability to put their message across. (6; p7, statutory)

Adapting to statutory structures – a positive experience of partnership

Although our informants were overwhelmingly critical and sceptical of the potential for genuine, equal partnerships between community and statutory, the perspective of the one informant who reported positive experience of such partnership provides further insight on potential statutory-community partnerships. This experienced voluntary sector leader took a 'pragmatic' approach to engaging with the statutory sector. He felt that in order to change the system, one had to work within the system, and thus, he was willing to adapt to statutory demands. He described the careful steps he took to ensure that collaboration with funding bodies and statutory organisations was successful. He reported keeping very careful accounts, and never applying for very large sums of money. He also said that he was careful to ensure that partners were well informed of his work, through giving presentations, showing photographs and sending them letters of thanks and written reports. The more positive experience of this informant, given his 'pragmatic' approach, is consonant with our observation that statutory decision-makers view 'partnership' as essentially involving 'business as usual'. Since this informant was willing to work within this model of partnership, fundamental questions of re-distribution of power were not a cause of conflict in his work.

Conclusions

In this paper, we have presented the views of African-Caribbean community members on potential 'partnerships' between statutory service providers and the local community as a means of improving mental health services. We have highlighted the obstacles to such partnerships in the interest of promoting more realistic approaches to building partnerships which acknowledge obstacles and endeavour to address them. Our study has revealed extremely poor prospects for inter-sectoral partnerships in this context, but we do not seek to claim that this study of this particular African-Caribbean community is representative of the relationship between African-Caribbean communities and statutory health services in the UK in general. The extremely high levels of distrust and low perceived levels of capacity, unity and sense of agency within the African-Caribbean community are surely a product of a particular local history of interactions between African-Caribbean people and the statutory sector. Thus, it is not the profound degree of distrust and antagonism that we claim as our key finding, but the relation between historical marginalisation and contemporary participation: that the possibilities of partnerships depend significantly upon the existing relations between statutory and community. The extent to which our findings apply to other community contexts is an issue for further empirical exploration, but we hope that our theoretical consideration of the relation between community context and participation may be useful for research and practice in other contexts.

Our findings paint a very negative picture of the prospects for partnership within the existing context. The picture is all the more pessimistic when one acknowledges the systemic perpetuation of such a lack of social capital, as theorised by Bourdieu, and as borne out in our findings. Drawing on remembered experiences of failures to take the African-Caribbean community seriously, and on general expectations of a lack of responsiveness to African-Caribbean issues, informants had low expectations of partnership initiatives. In the absence of community confidence in such procedures, proposed partnerships are unlikely to attract the significant participation necessary to make them work, and the danger is that such partnerships would fail to produce significant outcomes, further undermining the relationship. Similarly, inequalities in the cultural capital, the administrative skills and practices, valued in the context of statutory funding agencies, or in statutory-run meetings, disadvantage African-Caribbean community members, so that opportunities for their contributions are limited, and thus opportunities for constructing supportive social capital are missed. The very difficult task to be achieved, in this case, is to establish a break with the past. The danger is that efforts to overcome these initial obstacles to partnerships may themselves be vulnerable to the very same obstacles.

Although our research has shown up the massive obstacles to participation in this case, inter-sectoral partnerships remain absolutely necessary in order to relate a state health service to its local community, and hence, in what follows, we seek to come to some suggestions for strategies to overcome or pre-empt such obstacles, through a theoretical discussion of our findings.

'Bridging' social capital, by definition, is a relationship that links together groups with different characteristics. Thus, we should not expect homogeneity at the outset, with respect to definitions of the situation, the problems, or the appropriate means to address those problems. In the present case, it appears that very different definitions of the meaning of participation exist within the statutory sector and the community. Moreover, for informants from the voluntary sector, their distrust of the statutory sector meant that they tended to see 'participation' and 'partnership' as potential opportunities to bypass the statutory sector, rather than as ways of generating the collaborative inter-sectoral relationships that characterise 'bridging' social capital. However, all groups are committed to improving local mental health services, and many people positively valued the principles of partnership. This shared goal may provide a starting point for a collaboratory partnership.

Agreement on the model of 'partnership' that is to be employed in a statutory-community relationship is also of key importance. In the case that we have described, where the community's definition of partnership involves radical shifts in power, but that of the statutory sector does not, no matter what action is taken by the statutory sector, within its more restricted model of partnership, it is unlikely to satisfy the community's expectations, and risks further alienating the community. Where the model of partnership is agreed upon, however, as in the case of our voluntary leader informant who reported adapting to the council's demands, and gaining useful support from them, it seems that partnerships can achieve results. However, given the levels of distrust and the very

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different models of partnership generally held by statutory and community, much stronger and more elaborate communication channels are needed to generate a sense of a shared goal, and for shared understandings of appropriate action to be defined.

The issue of 'professionalism' – a form of cultural capital – is an important area of divergence between the potential partners, as it pinpoints different expectations as to how the partnership is to be carried out. Our informants felt that training of African-Caribbean community members in participatory skills and codes of conduct would help to prepare them for the expectations of statutory employees, regarding how meetings are to be carried out, or funding applications evaluated. We would add that participants from the statutory sector may need to be more flexible in their arrangements for the partnership, so that community members are not expected to participate in the same way as do employees of the statutory sector. While divergences among participants may lead to tensions, the very value of partnership is that it builds 'bridging' social capital between stakeholders from different groups, and thus their difference should be respected. The heterogeneity among statutory employees to which we referred might serve as a means of bridging this gap between statutory decision-makers and community. Locally-based African-Caribbean statutory employees who understand both the constraints under which the council functions, and the demands for radical change being made by community members may be able to mediate between the groups of potential partners.

The absence of trust in the good faith of the statutory sector will make it difficult for any initiative taken by the council to be received with enthusiasm by community members –

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even the initiation of partnerships to improve mental health services. In this context, it is of crucial importance that community members' attendance at any participatory fora is actively sought and facilitated, that the initiative for partnership is proposed jointly between the statutory sector and voluntary or community groups, and that tangible results are produced quickly. Clear, convincing steps which demonstrate a valuing of community input are needed. The provision of African-Caribbean meals at a local hospital was a concrete and straightforward achievement significantly appreciated by our informants, and similar steps may help to establish confidence. Gestures which recognise the value of community input and which reflect genuine efforts to maximise such input, in terms of decisions of timing and location of meetings, and remuneration for participants, would be a starting point for such demonstrations of genuine commitment. This will have to be backed up by commitment to significant power being given to local voluntary groups and lay voices, to avoid suspicion that the council is willing only to make small concessions.

'Bonding' social capital refers to the quality of the relationships among group members. These relationships depend upon the representations that community members hold about themselves as a community, that is, their social identity. Informants characterised their community as fragmented, disunited, unlikely to mobilise around the cause of improving mental health services, and unlikely to be able to have an impact on state mental health services. Perhaps as a result of such disunity, the voluntary sector was seen by members of the statutory as composed of small, isolated groups, whose legitimacy – their symbolic capital – was questioned. The low level of 'bonding' social capital seems to further undermine the possibility of fruitful 'bridging' social capital being generated. However,

the local voluntary ethnically-specific services were highly valued, their African-Caribbean leaders and staff were respected, and their attention to issues of black cultural identity were appreciated. These might provide positive starting points for the generation of a more empowered social identity, and a greater sense of solidarity in an important collective endeavour.

In the context of policy calls for participation and partnerships as means of addressing long-standing health inequalities, we have suggested that communities suffering from health inequalities may also be communities suffering from low levels of the ‘bonding’ and ‘bridging’ social capital which would support their participation. While participation and partnerships must be key tools to improving health service provision for ethnic minorities, we wish to emphasise that efforts to implement participation cannot neglect the pre-existing community dynamics, which may present profound obstacles to the effective conduct of participation. It is an extremely difficult task to disrupt the mutually reinforcing relationship between distrust between prospective partners and failure of their projects. We have suggested that constructing shared goals and models of participation, expecting difference, building community capacity in ‘professional’ skills, and using historical and cultural understandings to build empowered social identities are all things to be aimed for in the preparation stage for implementation of partnerships. In the early stages of the partnership, it is important that tangible changes are speedily implemented in response to the community’s voice. In the absence of supportive preparation for statutory-community collaboration, partnerships may become one more casualty of entrenched social inequalities.

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¹ Documentation of interview details is as follows: Interviewee number; page number, sector: (user/
voluntary/ statutory/ lay)