Community Development and Health Network (CDHN) is a regional network organisation, consisting of over 1800 organisations. We support and engage our network to advance their knowledge and skills in community development, to influence policy and to use community development to reduce health inequalities.

Community Development and Health Network

CDHN agree with the definitions of community capacity building and community development but feel the purpose for which they will be utilised should be made explicit. It is implied that community development and capacity building will produce communities which are able to develop local programmes, projects, build their internal systems, people and skills to “significantly influence the prevention of suicide and suicidal behaviours”. Community development and capacity building are excellent processes for working with communities to identify assets, needs, solutions and actions to influence health and wellbeing. CDHN fully agree with utilising community development for this purpose but feel that greater recognition of the structural influences on mental health and resilience is required. Community development is an important resource for strengthening links between communities and decision makers, enabling communities to influence external structures to address the needs and develop the assets of the community at a more strategic level.

Using community development for both purposes will yield improved outcomes over the longer term.

Tier 1 services have successfully shown how community development with an emphasis on capacity building and resilience can support communities. The continued funding of such services are vital especially while many communities, families and individuals continue to face worsening living standards, social exclusion and experience increasing inequality. This strategy clearly outlines how communities and services within the community can be utilised to help prevent and reduce suicide.

The strategy needs to acknowledge the impact of external structures on a community. Further to this it should outline how community development will be utilised to support communities to influence these structures. For example the recession has had a significant impact on mental health and suicide rates, a study by Barr et al 2012 attributed 846 more male and 155 more female suicides between 2008 and 2010 to the economic downturn. Areas of deprivation have been hardest hit by the recession. In Northern Ireland rates of suicide and self- harm continue to be higher in areas deprivation, (DHSSPISNI, 2014). Many policies, decisions and actions have led to high inequality and deprivation. Community development works to build stronger relationships between decision makers, service providers and communities. Stronger relationships would support a upstream approach to health and wellbeing and encourage co-production which can produce improved health outcomes and reduce inequality and deprivation. These processes can also promote empowerment and esteem with the community. A sense of empowerment and esteem has positive effects on health and wellbeing. (Lavrack, 2006)

CDHN would like to see the sentence “community development is dependent upon a certain level of capacity within the community” removed from the strategy. The sentiment implies that communities with little capacity cannot undertake community development. There are many instances where catalysts for change come from within the communities perceived as having little capacity. In these cases community development is undertaken, not by a professional or paid worker, but by individuals and groups within a community and will often led to the opening for successful professional and statutory interventions to commence.

CDHN agrees with the key performance indicators but taking the above into account would like to see an indicator which takes includes community engagement with service providers and decision makers. Under information management there is mention of PPI, this is decision makers engaging with communities to improve services and is qualitatively different from communities engaging with decision makers. (king and Cruickshant, 2010) The higher capacity, empowered and connected a community is, the more likely they are to be proactive in engaging with decision makers.

In section 2, capacity building and resilience, there are references to the community taking ownership and developing local initiatives. CDHN agree within this but feel there should be mention of the structural influence on mental health and resilience and how communities will be supported to shape and affect these.

The strategy is clear on how community development with an emphasis on capacity building can support communities to identify and address local needs with regards mental health, resilience and suicide. CDHN would like to see this built upon to include community development and capacity building to influence external structures and systems which impact on the health and wellbeing of the community.

For further information or clarification please contact:

Meabh Poacher, Policy and Project Officer

[meabhpoacher@cdhn.org](mailto:meabhpoacher@cdhn.org) 028 30264606