Community Health Enquiry

A working paper by the Cambridge Institute for Sustainability Leadership

The University of Cambridge Institute for Sustainability Leadership

The University of Cambridge Institute for Sustainability Leadership (CISL) is a globally influential Institute developing leadership and solutions for a sustainable economy. We believe the economy can be 'rewired' through focused collaboration between business, government and finance institutions to deliver positive outcomes for people and the environment. For over three decades, we have built the leadership capacity and capabilities of individuals and organisations, and created industry-leading collaborations to catalyse change and accelerate the path to a sustainable economy. Our interdisciplinary research engagement builds the evidence base for practical action.

Authors

Simon Lee, Associate Consultant, CISL

Ben Kellard, Director of Business Strategy, CISL

Acknowledgements

With thanks to Marion Birnstill, Johnson & Johnson Foundation and Caroline Lee, Senior Research Associate, CISL, for their insights and contributions throughout the project.

We are grateful to all the experts and pioneering practitioners who were consulted as part of this research. A list is provided in the annex.

Working papers are circulated for discussion purposes only. Their contents should be considered preliminary and are not to be quoted without the authors' permission. All views expressed are those of the author.

Executive Summary

The Johnson & Johnson Foundation commissioned CISL to explore the role and opportunities of community health as a mechanism for delivering improved health and resilience in communities. This working paper seeks to establish a baseline of shared knowledge and understanding, to inform future investments and actions of the Foundation and other funders, programmes/projects at the community level, and other actors across health systems.

Community health refers to the design, development and/or delivery (i.e. production and/or consumption) of services and activities by and within communities, which contribute to improved population health and resilience. The range of services and activities delivered is broad. We identify three main types of community (mental) health intervention at the programme/project level:

1. Community empowerment and capacity-building;
2. Social support and integration;
3. Community-based treatment and care.

In this paper, we use **community mental health** (CMH) as a lens to understand community health more broadly. We believe that community-based mental health provision could provide an efficient and effective solution, alongside other approaches. In this context, our definition of mental health is not limited to treating and managing mental health conditions; it encompasses a wide range of activities that can contribute to wellbeing and help nurture resilience.

We identify a number of '**principles for quality growth**' for the further growth and development of community mental health as a delivery mechanism, and for community health more broadly, adopting the multi-level perspective as an analytical framework:

- At the niche (project level) level – services targeted to where the need is; service user empowerment and involvement; structured engagement with local partners; strong programme to health system linkages; well-paid, trained community health workers/project staff; robust, consistent tracking of outcomes and impact; and knowledge networks and exchange.
- At the regime (health systems) level – health system recognition and buy-in for community (mental) health; a clear business case backed up by robust impact data; long-term, flexible funding and support for programmes and projects; and sufficient financial and professional capacity across the broader system.
- At the landscape (wider systems) level – a favourable or improving socio-economic context; policy recognition of and responses to the causes of individual and collective trauma; societal acceptance of mental health as an issue; and a favourable, joined-up policy environment.

Conversely, three key **systemic constraints** are identified that will continue to inhibit the effective development and growth of community health if left, including: a lack of appropriate funding and commitment; lack of understanding and recognition; an unfavourable socio-economic and policy context.

The key **investment opportunities** that we envision for funders in this space are:

1. Provide funding to pilot and test community health models.
2. Define and design the community health workforce of the future.
3. Create a movement to champion community mental health in Europe.
4. Build the evidence base to increase support and effectiveness.
5. Integrate pathways and intersections between individuals, communities and health systems.

Contents

Executive Summary 2
1. Introduction 5
2. Defining community health 7
3. Principles for quality growth 10
4. Pioneering programmes 14
5. Investment opportunities 17
Annexes 19
Annex A: Primary research – overview 19
Annex B: Secondary research – selected key sources 20

1. Introduction

1.1 The context for community health

Delivery of the UN Sustainable Development Goals[1] will require the rewiring of the economy[2] to one that is zero carbon, protects nature and is inclusive – promoting the wellbeing of all. The combined impacts of austerity and the pandemic have profoundly affected communities, revealing inequalities often missed by conventional GDP measures. Community wellbeing provides a powerful alternative lens to understand and seek to promote more resilient and inclusive societies[i].

There remains a significant unmet need in health systems globally. In low- and middle-income countries (LMICs), the most immediate challenge is the need to expand primary care and distribute medicines to reach those not yet covered by formal health systems. This challenge, if met, would achieve the goal of universal health coverage.[ii] In high-income countries (HICs), there is a need to reduce the growing burden on health systems of ageing populations and preventable diseases, such as diabetes and heart disease; address the growing prevalence of poor mental health and wellbeing, and tackle health inequalities.

COVID-19 has brought to light a need to rethink how health systems are financed, governed and delivered across the globe.

The Johnson & Johnson Foundation (J&J Foundation) aims to better understand the challenges and opportunities for improving health and resilience in communities, with an emphasis on health system transformation – rethinking the future of health systems to ensure that they are sustainable, resilient and inclusive.

CISL and the J&J Foundation want to better understand how that transformation could come about and the role that funding bodies, both public and private, can play in catalysing and accelerating systemic change.

In a recent think piece,[iii] the J&J Foundation set out its '2035 Vision' for building resilient health systems – by moving from curative to preventative healthcare and expanding the role of community health workers (CHWs) as a key delivery mechanism. The supposition is that community health can free up health systems to focus on 'upstream' delivery, i.e. treating diseases (in institutions), by delivering 'downstream' activities (in communities) that a) build new pathways and connections to the health system, and b) prevent diseases and illness through activities that contribute to improved overall health, wellbeing and resilience, of individuals and communities.

While digital health innovation (e.g. self-diagnostic equipment, smartphone apps) is helping to improve access to health services and empowering individuals to better manage their own health and wellbeing, there are limits to what can be achieved through digital and individual-level engagement – particularly in mental health, where physical isolation has exacerbated pre-existing needs during the COVID-19 lockdowns, as well as in deprived communities, which have typically higher levels of unmet need.

[1] https://www.undp.org/sustainable-development-goals
[2] https://www.cisl.cam.ac.uk/resources/cisl-frameworks/rewiring-the-economy

1.2 Research aims and approach

In this context, the J&J Foundation commissioned CISL to explore the role and opportunities of community health as a further mechanism for delivering improved health outcomes. This paper summarises the outcomes of structured research and engagement between October 2020 and June 2021.

In a field that is complex, still emergent and as yet lacking a robust, comprehensive evidence base on what works, this working paper seeks to establish a baseline of shared knowledge and understanding, to inform future investments and actions of foundations and other funders, programmes/projects at the community level, and other actors across health systems.

It is the intention of the J&J Foundation that further investments in this field, to prototype and test new approaches, will produce further learning to feed back into programmes and projects, thereby contributing to a virtuous loop of experimentation, acceleration, learning and iteration, and incentivising others to act.

A review of existing and emerging practices in community health was conducted in the first phase of the research, with a focus on European models, but also drawing inspiration from innovations in LMICs. This incorporated a desk-based review of leading organisations and existing research in the field of community health, as well as related areas, including integrated community care, social prescribing and asset-based community development. Initial interviews were conducted with selected experts in these fields.

This initial research suggested that mental health specifically is an area of growing need, especially in the post-COVID era; that it remains significantly underfunded and sometimes under-acknowledged, by formal health systems. Also that mental health, wellbeing and resilience is an area where communities can provide efficient and effective solutions – and indeed are already doing so, as illustrated by selected examples featured in this paper.

Therefore, the second phase of the research focused on community mental health as a lens for understanding community health more broadly. Further secondary sources were reviewed, and a series of further interviews conducted with a range of experts and pioneering practitioners in community mental health at the European, national and community levels. In total, more than 15 expert stakeholders were interviewed for this research.

Healthcare is high on every government agenda in the post-COVID world. We hope that this working paper can contribute insights for all actors across health systems to seize this opportunity to build forward better, make bold decisions, and collaborate across organisations and sectors to create resilient health systems that focus on prevention, not just cure.

2. Defining community health

2.1 Scope and nature of community health

Community health refers to the design, development and/or delivery (i.e. production and/or consumption) of services and activities by and within communities, contributing to improved population health and resilience. This represents a shift of power away from traditional, centralised, top-down health systems. Instead, with a much greater role for other actors across the public, private and voluntary sectors and communities themselves.

The scope of services and activities delivered is broad, particularly when health and resilience are understood as encompassing physical, mental and emotional health and wellbeing. By embracing preventative and more human-centred approaches, community health models can intervene and address actual or potential health problems before they reach the formal health system or other services – thus saving resources in other areas.

Based on the insights gained through the research for this paper, we propose below a typology that we hope will support system actors, practitioners, and stakeholders to better understand and locate the scope and nature of initiatives in this field.

We identify three models of community health intervention at the programme/project level:

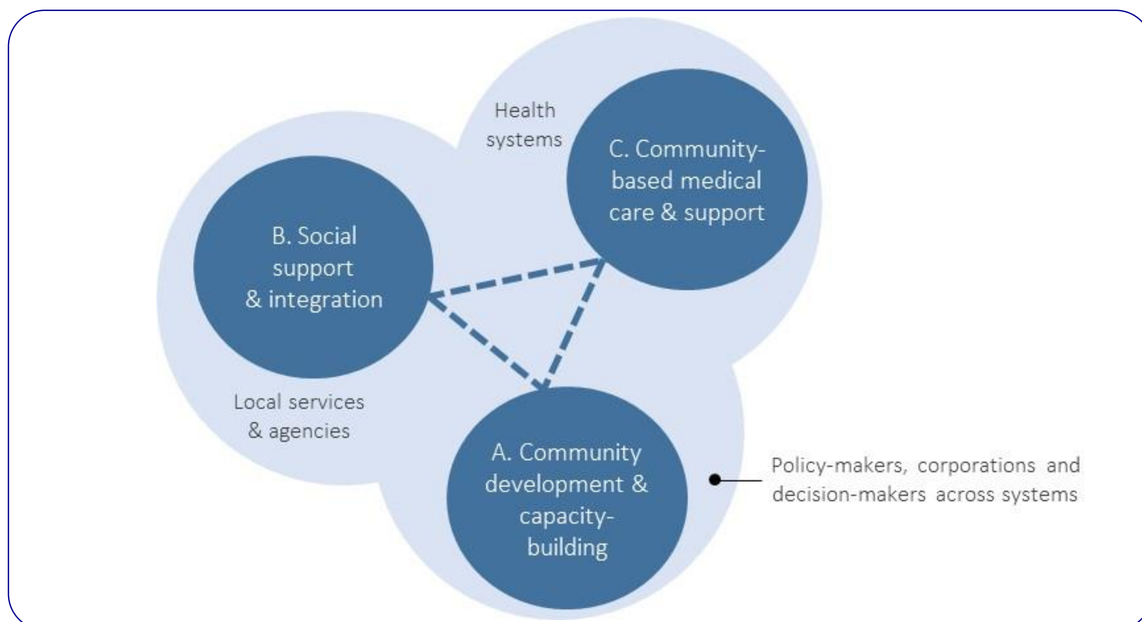


Fig. 1: Typology of community health initiatives

A. Community empowerment and development

Building the capacity of community and voluntary organisations (CVOs) to develop and deliver community health interventions while building the asset base within communities, as well as local representation and voice politically. These address broader social, economic and environmental conditions (namely social determinants of health) – such as insecure housing, employment, or factors related to law enforcement/the justice system – to enable better, more integrated decision-making. Bottom-up groups leading their own empowerment may drive these initiatives. The initiatives may be supported by engaging powerful actors at the city, regional or national levels, such as policymakers, public agencies and corporations. These interventions may be thought of as universal (whole community) and contributing to both prevention and management of mental health conditions.

B. Self-care and social integration

Personal and social resilience-building activities designed to help strengthen and promote a more integrated approach to physical, mental and emotional health and wellbeing. These include mutual self-help groups for people with mental health conditions; arts, sports and other activities that build social connection and inclusion; and mindfulness-based activities, such as meditation and yoga. Initiatives are typically delivered by non-governmental organisations (NGOs) and community-led groups, with varying levels of funding and support from a range of public, private or third sector sources. They engage and collaborate with a range of local services and agencies beyond the formal health system, such as social services, leisure and cultural services, etc. Often, these services may be targeted to help individuals manage existing mental health issues and/or to vulnerable groups as part of a preventative approach.

C. Professional diagnosis, treatment and support

Delivery of medical or psychiatric diagnosis, treatment and support in community settings (e.g. community health centres), usually by trained professionals or salaried community health link workers. In Europe (though not elsewhere), these are often funded or co-funded by public health systems. Increasingly, the private sector also plays a role, e.g. pharmacies providing basic health checks and medication. The size of the population regularly requiring such treatment and care (i.e. for diagnosable health conditions) is likely to be smaller than those reached by the other two types of intervention above.

In reality, there are significant overlaps and linkages across these three idealised intervention types. For example, through social prescribing, community link workers or family doctors may connect community members to social support and integration projects.

Technology plays a complementary role, e.g. private sector apps and public/third sector apps and websites that direct users to appropriate services and support. Since these are used/consumed within communities, they fit our definition of community health, but they are not a focus of our research or this paper.

2.2 Development and prevalence

Community health and resilience, as a concept and practice, is gaining traction in Europe and elsewhere. A few pioneering projects and programmes, including examples featured in this paper, are long-established, but most were established more recently. Furthermore, COVID-19 and accompanying restrictions on movement and access to services have increased the impetus on communities to innovate, collaborate and self-organise.

LMICs in the global south, with less developed and well-funded formal health systems, are often at the forefront of mainstreaming community health within those systems (such as in Ethiopia and Liberia).[iv] Salaried community health workers have been trained and empowered to dispense medicines and basic care as an efficient way to access harder-to-reach communities and accelerate progress towards universal health coverage.

In high-income countries, the challenges are different. Health institutions and facilities are well-established, but access and use remain uneven among different geographical and socio-economic groups; social inequalities are rampant in health systems and health outcomes.[v] Environmental, social and lifestyle factors are linked to a higher prevalence of certain physical (e.g. cancer, diabetes, obesity) and mental (e.g. stress, anxiety, depression) illnesses.

Community (mental) health programmes are complementary to formal health systems and can alleviate pressure on them by addressing or preventing medical conditions before they need treatment. This is particularly relevant in the European context, where growing demand and need for health and social care have been set against more constrained public finances since the financial crash of 2007/08, and will likely face further cuts post-COVID.

In Europe, there is growing recognition of and policy commitment to community (mental) health and mental health at the national and supranational levels. This remains uneven, but where it has happened, according to the experts consulted for this research, it has resulted in positive shifts in both rhetoric and action.

2.3 Community mental health

Community health addresses a range of physical, mental and emotional factors that contribute to health and resilience, often doing so holistically, recognising that these are interdependent and can be mutually reinforcing – for example, community sports teams that provide physical exercise and social connection. This may act as a helpful counter to the fragmentation of fields and services that often exists within health systems.

As noted above, in Europe there is a disparity between the need for and investment in mental health services, particularly as the former has expanded rapidly as a result of the COVID-19 pandemic. We believe that community-based mental health provision can provide an efficient and effective solution alongside other approaches. In this paper, we use community mental health as a lens to understand community health more broadly.

3. Principles for quality growth

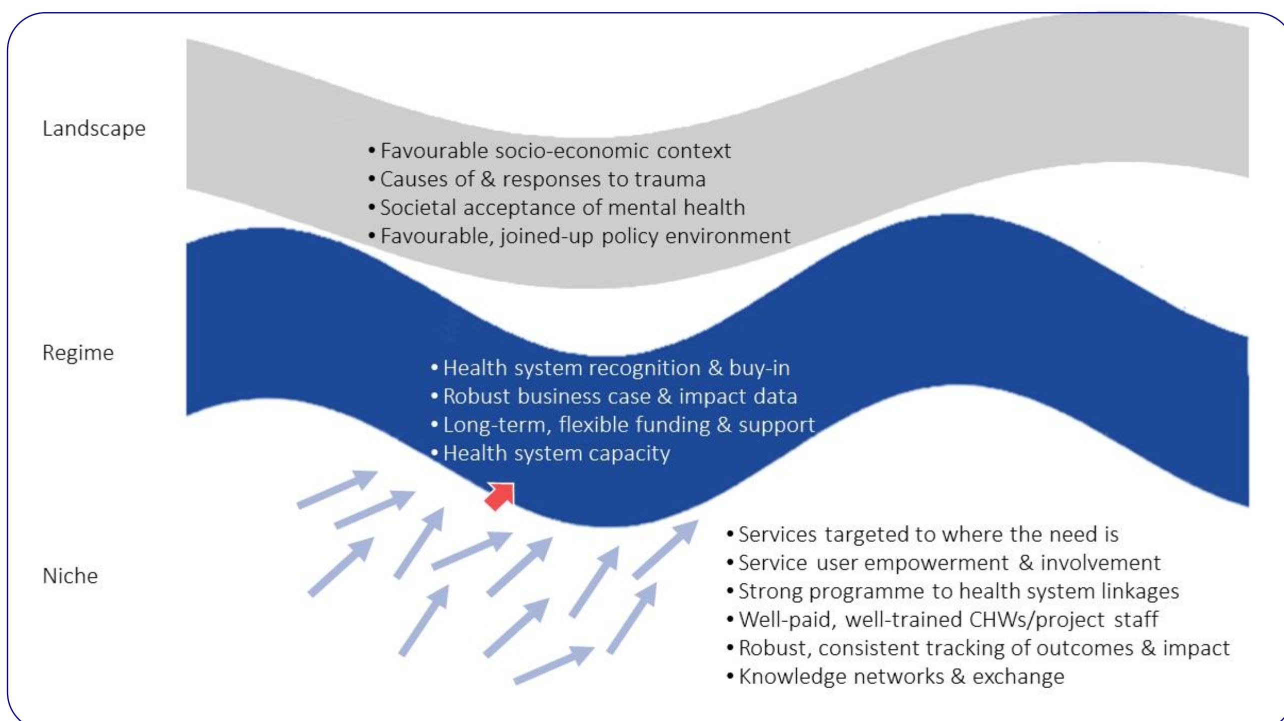
We recognise the valuable work already delivered by organisations including the Community Health Impact Coalition, London South Bank University, the Transnational Forum on Integrated Community Care (TransForm) and others to define good practice criteria and guidelines for community health and related fields. A few key sources and frameworks are summarised in Annex B.

Building upon these insights and drawing on the additional research conducted for this paper, we suggest below a series of good practice principles and enablers for expanding and further developing the field of community mental health specifically, in Europe, in an effective and impactful way.[3] Many of the principles are, however, applicable to community health more broadly.

The principles are presented within a multi-level perspective (MLP) diagram on the following page. MLP is a conceptual framework that helps to illuminate transitions in complex systems. The 'landscape' level refers to long-term, macro-level drivers that enable or exert stress on existing systems; the 'regime' is the ordinary functioning of the dominant system or systems, while the 'niche' is where new solutions are developed in response to shifting realities. As pressure on the regime grows, niche innovations may break through to the mainstream, supplementing or displacing existing models.

It is hoped that these principles will be helpful to funders and practitioners alike in informing new investments and programmes –both to expand the field of effective niche innovations (i.e. community mental health projects) and to enhance the preparedness of the regime (i.e. health systems) to enable, support and integrate these approaches, as appropriate.

Fig. 2: Principles for quality growth of community (mental) health



[3] Our observations are based on emergent practices from interviews with selected experts and pioneering practitioners. Given the small sample size, we identify emerging messages rather than seek to make robust, evidence-based claims.

3.1 Niche (project level)

Services targeted to where the need is.
Addressing physical, psychological or social/cultural barriers by delivering services and health system linkages visibly and accessibly within communities. These include physical spaces (e.g. community health centres, crisis support centres) and activities (e.g. football clubs, arts cafes, yoga groups), as well as personnel (e.g. health 'navigators') to help service users navigate what are often confusing and fragmented service offerings across health systems.

Service user empowerment and involvement.
It is often appropriate to consult community members as early as the pre-design phase; they may sit on governance structures as a project develops, or be involved in project management and delivery. This marks a significant shift from 'patients' or 'service users' as passive recipients to a model whereby communities are co-creators and co-producer of their own care and support. This is particularly relevant in the post-COVID era, as communities have adapted to illness and lockdowns by becoming more self-sufficient and mutually supportive.

Strong programme to health system linkages.
Regular engagement by community health projects with a range of upstream partners (e.g. health commissioners, local authorities, other decision-makers) and downstream stakeholders (e.g. food bank volunteers, paramedics). This engagement shares intelligence, identifies needs at the individual and community levels and coordinates action. It recognises that communities are themselves complex systems, with many moving, interdependent parts – while also integrating patient pathways from community health workers through to other frontline health workers, such as physicians and nurses.

Well-paid, trained community health workers/project staff.
Community health workers offer an empathetic, human face to community members; help navigate negotiations across multiple complex systems (e.g. public housing, benefits); and are a focal point for partner engagement and coordination. Given these diverse skill requirements, it is vital that they and other staff are well-paid, well-trained, supervised, and recognised by the formal health system. A programme that had not secured funding for paid staff told us that its dependence on volunteers was unsustainable.

Robust, consistent tracking of outcomes and impact.
Reliable, relevant evidence of impact is needed at the programme level to maintain support from funders – for example, quantitative measures aligned to funders' priorities (e.g. 'blue light incidents' prevented), or light-touch, user-generated qualitative data (e.g. participant diaries).

Knowledge networks and exchange.
Opportunities to exchange learnings from innovative approaches and identify, as a professional community, emerging findings on what works, for whom, in what circumstances and why. To date, many programmes have been proactive in joining or forming knowledge communities related to specific aspects of community health, mental health or community development of relevance to their work.

3.2 Regime (health systems)

Health system recognition and buy-in.
Being willing to relinquish some power and work in partnership with actors outside the formal health system is essential for community mental health programmes to be seen as credible, establish health system linkages and enable a 'seamless integration of services'. As part of this acceptance, health systems will need to consider what the health workforce of the future will look like, including CHWs.

Robust business case and impact data.
A stronger evidence base will further increase willingness to invest in community health. In particular, interdisciplinary research is needed to show how improved community mental health and resilience translates into broader health and social outcomes (and vice versa), and economic sustainability / return on investment.

Long-term, flexible funding and support.
Long-term funding enables programmes and workers to become truly embedded in communities, nurturing relationships and trust. Flexible and micro-funding allow delivery partners to be more agile and responsive to ever-changing community needs. An innovative model is highlighted in the following section.

Health system capacity.
To enable the points above, health systems must be appropriately funded and invest in maintaining sufficient professional capacity in non-community settings, including other primary care professionals such as family physicians/GPs, social workers and psychologists. The COVID-19 pandemic has pushed many health systems to their limits, but also expanded their reach more deeply into communities.

3.3 Landscape (wider systems)

Favourable socio-economic context.
Poverty, inequality, insecure employment and other socio-economic conditions shape people's lives and health in profound ways. These, in turn, are impacted by external factors and shocks such as financial austerity, technological disruption and climate instability, whose current trajectories look set to further disempower the most vulnerable communities. This implies a need to renegotiate the social contracts now under strain; community health, with suitable structures and support, could be an emergent expression of this.

Causes of and responses to trauma.
Exposure to trauma, individually and collectively, can be a valuable lens for understanding mental health – from bullying in schools or workplaces to PTSD in the wake of conflicts, natural disasters or pandemics. In the wake of COVID-19, loss of loved ones and increased isolation are exacerbating mental health challenges, requiring a society-wide response.

Societal acceptance of mental health.
Social attitudes to and discussion of mental health will influence the extent to which individuals are willing to

engage with community-based models of care and support. Social attitudes also influence the willingness of communities to accommodate preventative interventions. Experts told us that where mental health remains taboo, winning support for CMH approaches can be a more significant challenge.

Favourable, joined-up policy environment.
Political commitment to innovation in health delivery, and prioritisation of mental health, can lead to increased engagement with CMH by health system professionals. Furthermore, policies that encourage localisation and neighbourhood-based delivery of services can support cross-agency working in communities. At the same time, more comprehensive interventions in areas such as urban planning, social protection, accountability and governance can create a more favourable socio-economic context.

3.4 Systemic bottlenecks

Converse to the above success enablers, our research identified three key systemic bottlenecks and constraints to progress:

Lack of appropriate funding and commitment.
Insufficient funding, long-term commitment and recognition of the role and value of community health models. Also, short-term, inflexible funding which can undermine the continuity of presence and long-term relationship-building that is vital to effective programmes. Uneven policy commitment to tackling mental health.

Lack of understanding and recognition.
Established mindsets and cultures within formal health systems; scepticism or misconceptions among health professionals. Lack of hard evidence and consistent methodologies and data to demonstrate impact at the project level. A fragmented and emergent space that does not yet benefit from strong policy advocacy.

Unfavourable socio-economic and policy context.
Economic inequality and poverty, exacerbated by fragmented policymaking and a limited understanding of/action to tackle social determinants of ill-health, such as poor housing, unemployment or low-paid, insecure work. 'Task shifting' of responsibilities, policies and actions to enable community health and resilience – onto the health system, communities and unpaid/informal caregivers and volunteers.

In the final section of this paper (section 5), we propose investment opportunities that could help to address these constraints.

4. Pioneering programmes

We present below a small selection of programmes and projects identified in our research, which illustrate the principles set out in the previous section.

Creative Minds, UK

An award-winning charity developed and hosted by South West Yorkshire Partnership NHS Foundation Trust. Creative Minds promotes arts and movement, from an arts café to dancing in hospital corridors, to local sports groups. Its budgets are devolved to five local 'hub towns' and local collectives, which are run jointly by participants and staff.

The principles in action:

- **Long-term, flexible funding.** To bypass health system bureaucracy, Creative Minds was created as a 'link charity' in 2011 with £200,000 of initial NHS funding, which it redistributes downwards to VCOs. Match funding was provided by local authorities and national bodies, including Arts Council England and the Big Lottery Fund.
- **Health system buy-in.** Major health system actors like the NHS often have established cultures and mindsets; there may be scepticism or resistance to new approaches. Creative Minds nurtured a network of champions at varying levels of seniority, and distributed a magazine showcasing its concept, projects and successes.
- **Targeted services.** Health professionals (e.g. nurses, social workers) participate in five-a-side football and other Creative Minds-supported activities. This creates a different kind of relationship, bringing professionals to where the need is – enabling community members to access them in an informal, non-institutional setting.
- **User empowerment.** Community groups are offered micro-funding and flexible support, advice and training in areas such establishing themselves as legal entities, grant-writing and book-keeping. This helps build local capacity to design and deliver projects, while boosting participants'/co-creators' confidence and skills.
- **Robust impact data.** Creative Minds collaborated with the University of Huddersfield to develop new ways to evaluate its activities, training a peer-led network of Community Reporters. The research confirmed the "positive impact of creativity in supporting prevention, treatment and management of mental illness".

"If you help a person to find their passion, it can help them maintain their mental health and wellbeing for life." – Creative Minds

COFOR Recovery Training Centre, France

Gaining traction worldwide, the Recovery College model enables people experiencing or have experienced mental disorders to become experts in their own mental health recovery and wellbeing. COFOR, in Marseilles, is a Recovery College founded in 2017 on the principles of co-production and shared decision-making.

The principles in action:

- **Policy environment.** A new government policy to enable funding of more locally-focused health projects led to COFOR receiving its five-year funding from the Directorate General of Health (followed later by further support from Fondation de France). A current policy review means that funding beyond 2022 is not guaranteed.
- **Health system buy-in.** Two local mental health institutions understood and trusted COFOR from the start, which was crucial in establishing credibility and gaining referrals. Yet many professionals were initially sceptical, perceiving that the model may be seeking to compete with, rather than complement the health system.
- **User empowerment.** A range of local community mutual self-help groups joined COFOR's steering group, attending meetings alongside NGOs and professionals in mental health and community care. The steering group designed COFOR's training modules and course content and continues to oversee delivery.

"The system is organised to take care of people who are chronically ill, rather than to manage ongoing conditions" – Julien Grard, COFOR

Community Health Centre Botermarkt, Belgium

Beginning in 1978, a new, inter-disciplinary, community-oriented health promotion approach was pioneered in Ledeberg, in those days a very deprived neighbourhood in the city of Ghent. A community-oriented primary care strategy brings together local agencies to pool knowledge and data, link individual patients' issues to community-wide trends, and tackle health inequity by addressing social determinants.

The principles in action:

- **Engagement with partners.** Regular inter-agency meetings enable 'community diagnosis' and coordinated action. For example, poor childhood physical health and development, usually treated with physiotherapy, medication or dietary supplements, was addressed by redesigning local authority-owned play areas, leading to increased outdoor play and improved physical and mental health.
- **Addressing socio-economic determinants**. An advocacy action by health and social care workers to address poor housing conditions – an upstream cause of ill-health – helped to secure a €1 million investment from the city government and the region, alongside additional funding for social infrastructure.
- **Targeted services.** The community health centre provides integrated, interdisciplinary primary care for community members, and a shared location for its team. The aim is that there is access to care for patients with no distinction between physical and mental health, and other services.
- **Paid staff, embedded in communities.** Neighbourhood 'Health Promoters' are co-funded by the health centre and city government. This is supported by formal, written agreements with delivery partners within a 'Primary Care Zone' framework.

Community Mental Health Navigators, UK

With funding from the Johnson & Johnson Foundation, Rethink Mental Illness (part of Mental Health UK) has been piloting the Community Mental Health Navigator (CHMN) model in Grimsby since May 2020. CMHNs act as a single point of contact to support, guide and accompany patients in navigating a range of stressors that can contribute to poor mental health – from physical wellbeing and social connectedness to housing, personal finances and employment.

In 2021, as part of Johnson & Johnson's broader partnership with Mental Health UK, three more Navigators have been appointed across the UK.

The principles in action:

- **User empowerment.** The CMHN role was shaped by asking patients what they wanted – their answer was time. Overburdened doctors and social workers may only be able to spend a few minutes with each patient; CMHNs have time to sit with them, hear their concerns, and assess their needs holistically. This enables a user-centred model of support that simultaneously alleviates pressure on the formal health system.
- **Paid staff, embedded in communities.** Despite conducting many 'visits' on the telephone due to COVID-19 restrictions, the CMHN provides a range of practical, on-the-ground support, such as helping with food and medication deliveries, and advocating patients' needs in negotiations with local service providers. The skillset required is diverse, so having paid, trained and experienced Navigators is vital.
- **Health system buy-in.** Prior to the pilot, significant time was invested in engaging the local Primary Care Network (PCN) to convince doctors that the model had value and could help alleviate their workloads. Today, the PCN helps identify potential patients and makes referrals, as do a range of other health system professionals, including nurses, ambulance services and hospital liaison officers.
- **Favourable policy environment.** The new NHS Long Term Plan sets out a transformative vision for community-based support for people living with mental illness and complex needs, including increased emphasis on social prescribing, which complements the CMHN approach. This policy shift provides a rare opportunity to redesign services and scale up innovative models like the CMHNs.
- **Robust impact data.** To demonstrate to health commissioners that the model is effective and should be expanded, evidence is needed that CMHNs save money across the health system. Rethink Mental Illness is collaborating with renowned research centre The Tavistock Institute to evaluate the pilot and provide detailed insights regarding its impact.

"A Community Mental Health Navigator in every area would be a game-changer for the mental health of this nation"

– Jonathan Munro, Rethink Mental Illness

5. Investment opportunities

We suggest below potential investment opportunities for the Johnson & Johnson Foundation and other funders in this space, including health system actors and non-governmental organisations. These are informed by the desk research and expert and practitioner interviews conducted for this paper, and the researchers' own analysis of the emerging insights.

The recommendations are designed to help move innovations in community (mental) health from the niche to the regime – as represented by the red arrow in Figure 2, page 12 – by defining and scaling up (i.e. replicating, adapting and connecting) what works, while creating an enabling environment/addressing systemic bottlenecks within health systems, in the European context.

While not the focus of our recommendations here, we also strongly encourage policymakers, business leaders and other influential decision-makers – across systems and societies – to be mindful of the importance and impact of broader socio-economic and policy drivers at the landscape level and respond to these appropriately.

5.1 Recommendations

Our recommended areas for investment are:

1. **Provide funding to pilot and test community health models.**

Investing in piloting, testing and growing examples of the three community health models identified in this paper will provide further proof of concept, and insights into what works, for whom, in what circumstances, and why. We note the need for long-term, flexible funding, support and capacity-building for local partners, to enable the ongoing, paid employment of community health workers, embedded within communities. Therefore, we recommend minimum 5-year tranches of flexible funding to long-term partner organisations/institutions, which may then distribute smaller pots of funding for local partners to pilot, iterate and evaluate innovative approaches. Before establishing new programmes, it is essential to understand local needs and existing initiatives, then build on those.

2. **Define and design the community health workforce of the future.**

Well-trained, remunerated, and supervised community health workers, embedded within communities are key to maintaining effective engagement and dialogue with local partners and stakeholders. In LMICs, CHWs are often paid for by the health system; in Europe the context is different, with diverse actors delivering community health programmes and employing CHWs. Furthermore, not all workers who play a role in community health are necessarily formal health workers or perceive themselves as such. Further research and engagement are needed – with professional bodies, the health system and communities – to define what this emerging workforce will look like, the skillsets they will need, training delivery and their interfaces/collaboration with the formal health system.

3. Create a movement to champion community mental health in Europe.
Health system buy-in and support, both financially and in terms of recognition and collaboration, is vital if effective community-health system linkages are to be established and maintained. Community health, especially community mental health, needs to be advocated for and championed within and outside the health system – at practitioner and policy levels. Engaging and collaborating with existing networks and groups[4] where appropriate, funders should connect and grow a European-level network of community mental health experts, practitioners and advocates; establish a dedicated platform to share evidence and success stories; and leverage these to lobby policymakers to create an enabling environment.

4. Build the evidence base, to increase support and effectiveness.
A more robust evidence base is needed at the macro (national, European, global) and micro (programme) levels to convince health commissioners of the value and return on (social, as well as financial) investment, and help practitioners to better understand and enhance their performance. Funders should sponsor studies to explore the value of community health models and joined-up policymaking in improving health outcomes and preventing diseases; develop toolkits, innovative methodologies and standard indicators to capture programme-level impact; and commission economic modelling to forecast potential savings to health systems that could be realised through investments in community health.

5. Integrate pathways and intersections between individuals, communities and health systems.
Actions and interventions that impact health and resilience operate at the individual, community and health system levels, as well as being significantly influenced by broader social/structural determinants of health. Within communities, individuals are increasingly empowered to manage their own health, including through the rising uptake of tech-based/digital health; community health models are gaining recognition and becoming more prevalent; while health systems are providing more opportunities for collaboration/integration. Action research, utilising futures and systems thinking to better understand the intersections between these different levels, involving key actors across them, would help to improve integration and create seamless patient pathways.

5.2 Moving forward together

This paper demonstrates that health systems and communities are complex dynamic systems in constant flux, which operate and interact at multiple levels. Thus, achieving greater community health and resilience requires action across multiple levels by a wide range of actors and stakeholders.

Working together, funders and practitioners have an opportunity to accelerate the piloting, testing and scaling-up of emerging community health models – while policy-makers have a pivotal responsibility to create an enabling environment through better, more joined-up, longer-term policies and thinking.

It is the researchers' hope and intention that this paper will act as a rallying call for organisations across health systems and communities to engage in greater discussion, collaboration, co-creation and co-production in the space of community health.

The Johnson & Johnson Foundation is keen to play a greater role in this space and invites organisations interested in collaborating to discuss ideas and initiatives and explore potential synergies.

[4] A few are listed in Annex C of this paper

Annexes

Annex A: Primary research – overview

A range of experts and practitioners were engaged and consulted for this research at the European, national and local levels.

The experts consulted include:

- GAMIAN-Europe
- TransForm/ShiftN
- European Policy Centre
- European Alliance for Mental Health
- ABCD Institute / Nurture Development
- Fondation de France
- King Baudouin Foundation
- Mental Health Foundation

The pioneering practitioners consulted were:

- COFOR Project (Recovery Training Centre) Marseille, France
- Habitat Microaree, Friuli Venezia Giulia Region, Trieste, Italy
- Community Health Centre in Botermarkt, Ghent, Belgium
- Ups & Downs Association, Ghent, Belgium
- Creative Minds, South Yorkshire, UK
- Mind Crisis Sanctuaries, Cambridge & Peterborough, UK
- Mental Health Navigators, managed by Rethink Mental Illness, UK

Conversations in the latter research phase, particularly those with pioneering practitioners, took a semi-structured interview format. Our questions focused on:

- Prevalence and development of community (mental) health as an emerging field, including recognition, action, existing research and evidence, and examples of pioneering practices
- For the examples of pioneering practice that we spoke to directly, understanding:
    - The context, objectives, delivery model, funding and scale
    - Key success factors at the project and systems level
    - Key constraints and how these impacted the programme/project
    - Linkages between the programme/project and the formal health system
    - Impact achieved, and the evidence base for this

Annex B: Secondary research – selected key sources

In addition to the primary research, a desk-based review was conducted to identify, synthesise and build upon existing insights and frameworks in the field of community (mental) health.

Selected key sources are highlighted below. This is intended to signpost useful resources to further illuminate the field and context for potential funders and practitioners. It is not an exhaustive list.

Community Health Impact Coalition

The Community Health Impact Coalition (CHIC) exists to make professionalized community health workers a norm worldwide, focusing on developing countries.

It aims to catalyse the adoption of high-impact community health systems design by: 1) identifying practices that lead to quality care delivery; and 2) accompanying partners to adopt those practices.

According to CHIC's 'design principles', for community health workers to be effective, they must be:

1. Accredited
2. Accessible
3. Proactive
4. Continuously trained
5. Supported by a dedicated supervisor
6. Paid
7. Part of a strong health system
8. Part of data feedback loops

For CHW programmes to succeed on a national scale, they need 'the key three': political will, financing, and system design and implementation.

Source: https://chwimpact.org/ (accessed June 2021)

London South Bank University (2019), The Asset-based Health Enquiry – How best to develop social prescribing?

The social prescribing initiative set out under the NHS long-term plan was now being implemented by NHS England (2019). The inquiry sought to explore a number of key issues in social prescribing, understand what it is and isn't, and identify 'how it should be done'.

The report set out the following key elements for success:

1. Purpose – Holistic and based on genuine needs, starting with asking the question about 'what makes a good life' for individuals
2. Measurement – success measured in terms of meeting those needs, and shaping a system that can be capable of meeting those same needs sustainably in the future
3. Status – carried out by a mixture of entrepreneurial professionals and local people who understand each other and have generated their approaches together

4. Method – based as far as possible on emerging face-to-face relationships, with everyone taking part willing to change themselves
5. Language – describing the role increasingly as social or community connectors, without getting too precious about it
6. Costs – using small amounts of money to support local people to create the necessary local networks of support; investing to enable an asset-based model
7. Scale – managed as far as possible at the level of the identifiable community (usually a neighbourhood or practices) networked across whatever area seems appropriate
8. Significance – understood by those taking part as a new model of care: shifting responsibility to include people, practices and local collaborators, using the concept of New Power

Source: https://openresearch.lsbu.ac.uk/item/886v8

PHCPI – 38 Core Indicators

PHCPI is a partnership of country policymakers, health systems managers, advocates and others dedicated to transforming the global state of primary health care. The partnership aims to catalyse primary health care improvements in low- and middle-income countries.

PHCPI's 38 Core Indicators provide a snapshot of primary health care performance based on existing, globally comparable data, grouped under five categories:

- System – PHC spending per capita ($USD); % of government health spending allocated to PHC; government PHC spending as % of current PHC spending; out-of-pocket PHC spending as % of current PHC spending
- Inputs – basic equipment availability; essential drug availability; vaccine availability; facilities with clean water, electricity, sanitation; health centre density; health post density; community and traditional health worker density (per 1,000 population); nurse and midwife density (per 1,000 population); physician density (per 1,000 population)
- Service delivery – perceived access barriers due to treatment costs; perceived access barriers due to distance; provider absence rate; diagnostic accuracy; adherence to clinical guidelines; caseload per provider (daily); DTP3 dropout rate; treatment success rate for new TB cases; care-seeking for suspected child pneumonia
- Outputs – demand for family planning satisfied with modern methods; antenatal care coverage (4+ visits); births attended by skilled health personnel; DTP3 immunization coverage; children under 5 with diarrhoea receiving ORS; TB cases detected and treated; people living with HIV receiving ART; use of insecticide-treated nets for malaria prevention; cervical cancer screening rate; hypertension control; diabetes mellitus control
- Outcomes – under-five mortality by wealth quintile; maternal mortality ratio; premature NCD mortality; under five mortality rate; neonatal mortality rate

Source: https://improvingphc.org/phcpi-core-indicators (accessed June 2021)

TransForm (2020), Integrated Community Care 4all: New Principles for Care – Strategy paper to move ICC forward

TransForm (Transnational Forum on Integrated Community Care) is a joint initiative of Foundations in Europe and Canada that aims to put the community at the centre of primary and integrated care.

The strategy paper consolidated learnings from three TransForm conferences held in Hamburg (2018), Turin (2019) and Vancouver (2019), aiming to reinforce the case for Integrated Community Care (ICC) by charting the state of play around the shift towards ICC in health and social care systems. It identified seven 'effectiveness principles' for ICC, under three pillars:

Co-develop health and wellbeing, enable participation

1. Value and foster the capacities of all actors, including citizens, in the community to become change agents and to coproduce health and wellbeing.
2. Foster the creation of local alliances among all actors involved in the production of health and wellbeing in the community. Develop a shared vision and common goals.
3. Strengthen community-oriented primary care that stimulates people's capabilities to maintain health and/or to live in the community. Take people's life goals as the starting point.

Build resilient communities

4. Improve the population's health and reduce health disparities by addressing the social, economic and environmental determinants of health and investing in prevention.
5. Support healthy and inclusive communities by providing opportunities to bring people together and by investing in both social care and social infrastructure.
6. Develop the legal and financial conditions to enable the co-creation of care and support at community level.

Monitor, evaluate and adapt

7. Evaluate continuously the quality of care and support and the status of health and wellbeing in the community through participatory 'community diagnosis' involving all stakeholders.

Source: https://transform-integratedcommunitycare.com/strategy/

University of Westminster (2017), Making Sense of Social Prescribing

A guide was commissioned by NHS England, incorporating research from a Wellcome Trust-funded seed award: 'Investigating the provision and conceptualisation of Social Prescribing approaches to health creation'. It identified six 'essential ingredients of social prescribing schemes':

1. Funding commitment
2. Collaborative working between sectors
3. Buy-in of referring healthcare professionals
4. Communication between sectors
5. Using skilled link workers within the social prescribing schemes
6. Person-centred service

Source: https://westminsterresearch.westminster.ac.uk/item/q1v77/making-sense-of-social-prescribing

Annex C: Health networks and groups

Through conducting the research that informed this paper, some existing networks and professional groups were identified in relevant fields such as health and social care, community health, mental health and social prescribing.

We list below a few key networks and groups at the European level and within Europe of which we are aware:

Community Health Acceleration Partnership
www.chap.health

EU-Compass for Action on Mental Health and Well-being
https://ec.europa.eu/health/non_communicable_diseases/mental_health/eu_compass

Mental Health Europe
www.mhe-sme.org

NIHR School for Public Health Research (SPHR) Public Mental Health Network
www.sphr.nihr.ac.uk/research/sphr-public-mental-health-network

The European Community based Mental Health Service Providers (EUCOMS) Network
www.eucoms.net

The MARCH Network, University College London
https://www.marchnetwork.org/

TransForm – Transnational Forum on Integrated Community Care
www.transform-integratedcommunitycare.com

Westminster International Centre for Social Prescribing
https://www.westminster.ac.uk/research/groups-and-centres/westminster-international-centre-for-social-prescribing

Annex D: References

[i] Wiseman J, Brasher K. (2008). Community Wellbeing in an Unwell World: Trends, Challenges, and Possibilities. *Journal of Public Health Policy*, 29, 358.

[ii] World Health Organization and the International Bank for Reconstruction and Development / The World Bank (2017). Healthy systems for universal health coverage – a joint vision for healthy lives.

[iii] Birnstill, M. (2021), Building Resilient Health Systems: A 2035 Vision. Retrieved from: https://chwi.jnj.com/news-insights/building-resilient-health-systems-a-2035-vision

[iv] Van Nieker, L. et al. (2017). Social innovation in health: case studies and lessons learned from low- and middle-income countries.

[v] OECD (2019). Health for Everyone?: Social Inequalities in Health and Health Systems.