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Building Helping Skills: A Case Study in Inclusion Involving Collaboration Between Formal and Informal Systems

by

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Preamble

As health and social priorities shift, so shifts the language in which we talk about them. Terms which start with a certain meaning become ambiguous with wider usage. Bureaucracies outside institutional walls attach the word "community", which describes a dynamic entity of people and social groups, to their programs. Likewise we loosely use the term "participation" to cover a range of activities from token presence to active decision making.

For more than two decades, community participation has been a major theme in health promotion projects and funding streams. The logic is that, if people take part in identifying their health needs and deciding how these needs should be met, the health system will be more effective and citizens will have a greater sense of control over their health. However, the deficit crisis of the nineties fuelled political will to devolve responsibility for health care closer to the community.

Across the country, regionalisation of health services was an effort to rationalize an a health care system seen to be increasingly unaffordable. Collaboration with "informal" systems, such as caregiver and consumer groups, became recognized as a way to tap into less costly resources. This also fits with the Population Health model, which identifies *participation in community as an important determinant of health.* However, a major pitfall of the rush to participation has been the lack of appreciation of the dynamics of unequal power.

More recently, we have started using the term "inclusion" to refer to citizen participation. The concept of inclusion adds a new dimension to participation because it points to the importance of reaching out to those who are "excluded" from the mainstream activities of society. For a variety of reasons – such as poverty, unemployment, lack of education, disability, gender, and age – some citizens are shut out, disempowered, recipients rather than participants, with little say in determining the services that directly affect their lives.

Overcoming barriers to inclusion is not a simple matter. Our systems are bureaucratic and hierarchical in nature, and consultation procedures can be intimidating even for the experienced. Excluded people have often had little opportunity to acquire the skills and know-how, let alone the confidence, to participate in the formal system as it exists. Efforts to encourage consumer membership on boards and committees often founder on inequity and a clash of social cultures.

Genuine participation happens only when the opportunities are meaningful, and it involves the growth of mutual understanding. The term "inclusion" is most useful to the process when we think first about the aspects of "exclusion" that we need to reverse. It helps us focus more precisely on the practical steps to reducing exclusion.

Inclusion can begin and grow in diverse ways. The formal and informal sectors can collaborate in areas beyond the boardroom, in ways that lead to active participation. The following case study describes one such process.

Background

In 1992, the province of Newfoundland and Labrador faced an unprecedented crisis: a moratorium on the fishery which supported, directly or indirectly, the livelihood of about one fifth of its population. Hundreds of small communities around the intricate coastline lost their raison d'être. This crisis threw into question the future of people who for generations had lived by the fishery or related occupations.

The mental health implications of this situation were quickly identified. Who would provide the services to help people through this crisis? Already overstretched and under-resourced, Newfoundland's helping services were thin on the ground in most rural areas and non-existent in others. Who would help people cope?

In 1993, the Canadian Mental Health Association, Newfoundland and Labrador Division (CMHA), set out to ask people and communities how they were faring. "A Needs Assessment for Community Self-Help," funded by the Health Promotion Contribution Program (HPCP), Health Canada, was a participatory research project conducted in 27 communities affected by the Northern Cod Moratorium. The project looked at the impact of the first two years of the moratorium on the well-being of individuals, families and communities.

The project report, Working It Out: the Challenge of Change from Within (CMHA 1994), identified much innate strength and resiliency alongside significant distress resulting from loss of employment and, in particular, loss of a traditional way of life. Many people expressed concern about the lack of helping services available in rural areas, and about the erosion of social support resulting from the tensions and changes caused by the moratorium. Many asked the question, Who would provide this support when individuals, families or communities needed it?

At the same time, the provincial health system was also undergoing radical change. The province was establishing Regional Community Health Boards with responsibility for health promotion (including community development), mental health and addictions services, among others. But the new boards were seriously under-resourced when it came to creating new community services.

At the Atlantic Regional level, one of Health Canada's priorities was to encourage the development of partnerships between the formal and informal sectors in addressing health needs. With funding from the Health Promotion Contribution Program, CMHA created the Building Helping Skills Project, which focussed precisely on this area of collaboration.

The Exclusion Issue

When people in communities, citizen leaders and health professionals predicted widespread emotional distress in the wake of the Cod Moratorium, the prevailing assumption was that people needed professional helping services. CMHA questioned this. What was happening was a widespread adjustment to loss – loss of occupation and the identity that goes with that, loss of an accustomed way of life and source of income, and deep uncertainty about the future. People were experiencing the natural responses of grieving, including denial, anger, depression, and anxiety about what the future would hold. Certainly some individuals would need specialized help, especially where the stress created by the moratorium exacerbated existing problems or vulnerability. However, for the most part, what people need in such circumstances is understanding and support and the opportunity to recover some sense of control over their lives.

Amidst the dislocation and uncertainty, there were many exclusionary dynamics at play. These include exclusion from the workforce, exclusion from the decision making that was happening at the highest levels of government, and exclusion from information and resources needed to plan for the future and from access to services needed to ameliorate the present. The fear was that whole communities, as well as individuals and families within them, would become marginalised and reduced to poverty.

In this overwhelming situation, there were many factors which were not within people's control – the state of the fish stocks, the decisions of government. It was important to find places where people could start taking control. When people have an opportunity to deal with their immediate distress, it becomes possible to mobilize energy to address the larger advocacy issues.

In his famous paper, *John Deere and the Bereavement Counsellor*, John McKnight illustrates how the assumption that professional help is best can disempower the natural helping resources of the community. The CMHA proposal to Health Canada built on this point:

> Isolated Newfoundland communities have historically been extraordinarily resourceful in dealing with their own human problems and survival issues. Helping skills, indeed, are natural human abilities possessed by many individuals and readily recognized by those who turn to them for support. In recent decades, however, such skills have been defined and taught by professions such as social work and nursing, and developed to a high level of sophistication by psychotherapists and counsellors. This "professionalization" of helping, and the placing of ultimate trust in the expert, have in many ways undermined the role of informal resources. There exists a kind of mystique about professional counselling that engenders lack of confidence for many people in their own helping abilities. *(Proposal*, p. 4)

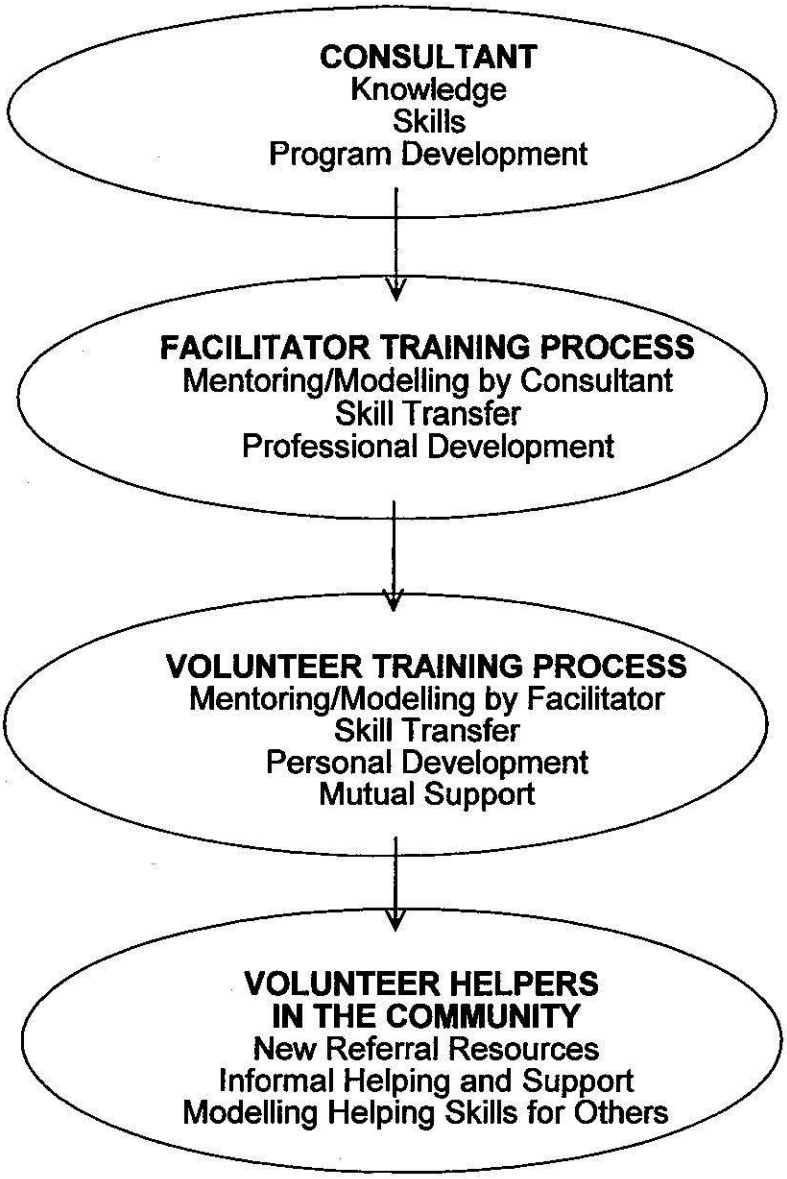
On the one hand, community people had in many ways become "excluded" from a legitimate role; on the other, those in need of help often could not get timely access to the helping services of the overstretched health care system. CMHA proposed that it was time to return the core skills of helping to the community.

The Inclusion Process

There are many aspects to an exclusionary dynamic which has happened over time. People on different sides of the barrier have to create bridges and build trust. CMHA started by proposing the development of a new helping resource, a network of community volunteers trained in the essential skills of helping, to whom health professionals could refer people who needed understanding, support, and a confidential listening ear. The proposal envisaged the reduction of waiting lists and the release of professionals to use their more specialized skills with those in greatest need. It also proposed a new role for some health professionals, that of providing training in helping skills to interested people in their communities.

Two of the new Community Health Boards agreed to be partners in this process, seeing in it a way to implement their mandate for community development as well as mental health. CMHA proposed a train-the-trainer model – although the word "facilitator" was used in preference to "trainer" (see Figure 1). CMHA would develop the content and provide facilitator training to counsellors employed by Community Health. The counsellors would then deliver the program to volunteers in their communities. The basic assumptions were there were people in communities who possessed the motivation and innate capacity to help others; with training they could develop and enhance their skills in helping others; by taking referrals they could free up the counsellors to do more specialized work; and whether or not the referral process worked, the training would contribute to building informal helping capacity in the community. The training would necessarily make a clear distinction between the activity of "helping" and that of "counselling" or professional therapy, and enable volunteers to identify their own limits and recognize when they needed more specialized help.

Figure 1: The Skill Transfer Process: How It Works



CMHA designed the project to unfold in three phases. Phase I, "Train the Trainers", encompassed a critical planning process, the development and delivery of the facilitator training program, and the writing of the Facilitator's Manual. This phase explored and established partnerships with the St. John's and East Region Community Health Boards. The management teams agreed to commit staff time to the project, and each region nominated a representative to the Steering Committee. These representatives were senior managers who took responsibility for identifying potential facilitators among staff in their regions.

In Phase II, "Transferring the Skills", facilitators' recruited volunteers and delivered the training program in their communities. Phase III, "The Network in Action", involved the volunteers

working with people who were referred to them, as well as using their training in their own families and relationships. An independent evaluator evaluated each phase.

A prime concern throughout the project was the question of *sustainability*. Would the Community Health Boards commit staff time to supporting the volunteer networks after the project was over? Would the facilitators be allowed to train new groups of volunteers?

The project had outstanding talents on its team. Susan McConnell, a practising psychotherapist with many years of experience in the social and mental health fields and a gifted teacher and facilitator, served as Project Consultant. In designing the train-the-trainer program, Susan distilled her extensive knowledge of human dynamics and the essentials of helping into a finely crafted process which worked simultaneously on two levels: drawing out participants' own knowledge and experience of what it means to be helpful and to be helped, and teaching participants how to replicate this process with their volunteers. The combination of information, experiential exercises, and discussion is challenging both intellectually and emotionally and involves a pivotal shift in understanding on the part of participants.

Leslie MacLeod, herself an experienced adult educator and facilitator, wrote the Facilitator's Manual. Leslie sat in as an observer of the first round of training. Working with Susan's structural plan, she documented the training process and wrote a manual which provides a comprehensive "road map" with all the required information, questions and exercises.

The facilitators who took the original training were vital to the project's success. They made a major commitment of time and effort without any certainty about the outcome and brought a healthy blend of enthusiasm and skepticism to the process. Key to their involvement was their first-hand knowledge of the needs and scarcity of resources in the communities they served. Without exception, they came into the project believing that Building Helping Skills was a good idea, but how and whether it would work was wide open to discussion. They engaged in a learning process which challenged them to deconstruct assumptions about helping and to work with their experiential knowledge of what is helpful and what is not. Their responsiveness to this approach, their questions about how it would work with community volunteers, their doubts about finding suitable volunteers, their anxieties about the competence of individuals and issues such as liability, their discovery of the enthusiasm and commitment of their volunteers, their growing confidence in the abilities and capacity of the people they were training, their excitement that the skill transfer process was working effectively – these experiences embody the substance and texture of the project. The first group of facilitators broke new ground, letting go of established thinking and trusting the ability of people in the community. They discovered the potential, validation of risk-taking, and liberation from the burden of responsibility of a genuine community empowerment process.

Most importantly, there were the volunteers, the people who came forward in their community and committed their time to taking the training program. Contrary to their initial concerns, the facilitators had no problem finding volunteers. They found that people were hungry for this kind of learning and recognized the need for these skills in their communities. "It's about time," was the response of one person. Enthusiasm remained high over the three-month volunteer training program, and the week between sessions allowed people to digest their learning and, as time went on, to put their new skills into practice in their lives. Individuals reported positive changes in the way they responded to family members and friends and, by the end of the program, were eager to start receiving referrals.

Facilitators were most concerned about this final stage of the project. They were aware of the strengths and weaknesses of their volunteers, and in a small number of cases were doubtful about

making referrals to them. What was their liability in referring clients of Community Health to volunteers? What if a volunteer made a mistake? How would they deal with the few people they thought were not suitable to receive referrals? Much energy went to addressing these questions. During Phase III, "The Network in Action", these issues were unravelled in ways that provided a much sounder understanding of effective collaboration between the formal and informal systems.

What Worked Well

First, the training program itself worked superbly. It is quite challenging to describe just why it was so effective and what distinguishes this program from others that use the train-the-trainer model. The essence of it, however, is that the process involves the deconstruction of preconceptions and clarification of assumptions, and that the learning grows out of the examination of experience rather than the acquisition of information.

In creating the program, Susan set out to develop a process through which participants would identify their own innate knowledge about what was helpful and learn how to use this knowledge effectively with other people. It was not a "putting in" of information, but a "drawing out" and development of skills grounded in personal experience and reinforced by discussion and practice. Certainly the program imparted a considerable amount of information, and theoretical models such as the Victim Triangle and Berne's Ego States expanded participants' awareness and understanding. However, the process focussed on the individual as the instrument and on using one's own experiential knowledge as the touchstone for what would be most helpful to others. Role play exercises and small group discussion of examples identified by the participants themselves provided abundant material for demonstrating the core dynamics of helping. Program facilitators encouraged people to use small rather than large life issues, for example, dealing with an unhelpful sales clerk rather than a major relationship problem. As the mutual trust within the group grew, members tended to use more personal issues.

Fundamental to the process were some key approaches: *demystification* of the helping process, *clarification of assumptions* underlying helping, and *deconstruction* of ideas about what a helper does. At the train-the-trainer level, the professionals took a long hard look at the habits and assumptions of their own practices and their evaluations showed that they found it both challenging and refreshing to get back to the basics. Although the volunteers required less deconstruction, there was a sense of direct connection with their own experiential knowledge which was both validating and energizing. All participants drew on their own knowledge of "what's normal" at different stages of life and "what's normal" in a crisis. Playing the roles of both helper and client by turns, they quickly identified the essential skills of tuning in, listening, sharing feelings, and self-disclosure. Having grounded themselves firmly in experience, they were able to recognize the often misunderstood response of Rescuing, and to apply the concepts of Child, Parent and Adult ego states to the helper's role. They were thus able to move from simplifying the helping process to the use of quite sophisticated theories in understanding some of the pitfalls.

The Skill Transfer process also worked exceptionally well. Having experienced all the exercises and activities, the trainers were well equipped to go on to present them to the volunteers trainees. Susan modelled the skills of listening, clarifying and supporting, and served as a mentor to facilitators in addressing problems and difficulties. The facilitators in turn served as model and mentor for the volunteers they trained. They found that the material worked equally well at both levels and with a wide variety of participants. For example, retired or unemployed professionals comprised one volunteer group, while former clients of the facilitator comprised another.

The different time spans of the two levels also worked well. For the facilitators, the training took place in a short, total immersion period. Although they found this "pressure cooker" approach quite exhausting, it enabled intensive learning. For the volunteers, the spacing of the sessions at weekly or twice-weekly intervals allowed them to digest and absorb their learning and to practise the skills they were acquiring between sessions. The total length of the program enabled the volunteers to thoroughly internalise this developmental process over a period of months.

The response of the volunteers, as already suggested, was the most positive aspect of the project. All were people to some extent accustomed to playing the helper's role with others, and all wanted to know how to do this better. As they demystified common myths about helping and grounded themselves in their own experience, there was a marked growth of confidence and self-value in the helper's role. Clarifying assumptions about helping, learning how to set boundaries, and to distinguish real helping from rescuing were "ah-ha" experiences for many volunteers. When they saw that certain responses – the urge to find answers or give advice, to take responsibility for other people, or to give more time than they really wanted to actually undermined effective helping, they were relieved of much of the anxiety and stress associated with helping.

As these insights developed, volunteers wanted to use them in their own lives. And this is where the real excitement in the project happened. People would come back to class the following week with an example of how differently they had handled an exchange with their mother, their teenager, or their neighbour. They were quite elated by how well their new approach had worked. "I feel like I listened properly for the first time, instead of jumping in with advice," was one comment. By the end of the project, feedback showed that the volunteers had integrated their skills into their lives and felt much more confident about how to be genuinely helpful to the people they knew. "I feel like I'm a better person because of it," was another comment. Taking the program had the effect of enhancing people's self-esteem.

It was at this point that we started to realize that the informal impact of Building Helping Skills was likely to be more important than the creation of a referral resource. The people who had learned new skills were touching countless others. They were modelling a different way of being helpful to their children. This dynamic was developing community capacity in the most fundamental sense. The extent to which they would also serve as a referral resource became, as we shall see below, the most debated question of the whole project – a question which pinpointed the fundamental difference between the formal helping system and the essential nature of community.

What Worked Less Well

Glitches or unexpected obstacles are often the most important sources of learning. This project was certainly not without its struggles. Many of these occurred in the first phase, as we worked out how to make the cross-sector connections that were essential if the project was to go anywhere. Who would identify the trainers? What kind of community networking would be needed to promote interest in the program and recruit volunteers? Where would the volunteers come from? What about the screening of volunteers? And the questions asked loudest and longest, How would referrals be handled? Was there a liability issue?

Many of these questions were answered as the weeks progressed, steadily casting new light on previously uncharted ground. The Community Health representatives on the Steering Committee played a key role in identifying the trainers and in ensuring that their workplaces supported them

in their new role. Because all the facilitators had systems of connections (both formal and informal) within their communities, recruitment of volunteers developed quite naturally. Clearly, there was an essential readiness among people to respond.

The issues that proved most intractable related to referrals. Facilitators working as professionals wrestled with how a referral system would work. How would they match referrals and volunteers? Who would be responsible? They worried about liability. What if they referred a Community Health client to a volunteer and something went wrong? Was the counsellor liable? was Community Health? was CMHA? After a great deal of discussion and consultation with the provincial Volunteer Centre and other programs utilizing volunteers, facilitators concluded the principle of informed consent on the part of clients covered this issue.

The suitability of some volunteers to receive referrals concerned the facilitators. How to screen them out, a highly sensitive issue when volunteers are donating their time, also concerned them. During Phase III, "The Network in Action", some real illumination happened. We gained a much sounder understanding of the nature of the collaboration between the formal and informal sectors that we had set in motion, and what aspects of this collaboration did or did not work well, and for what reason.

We had designed this project to create a referral resource, and recruited the volunteers on the assumption that they would receive referrals through the formal system. Phase III was the testing ground for this assumption. In the event some received referrals and some did not. The individual facilitator's concern about the suitability of an individual volunteer was the least of the reasons. There were two whole groups in two communities that received no formal referrals at all.

What we learned was that the willingness of people to be referred to volunteers in their community depends on the nature of the community. In small communities where anonymity was virtually impossible, no one wanted to be referred. At the same time, everyone in these communities knew exactly who had taken the training and could approach them informally if they wanted to. This was how the process worked in these communities.

In other communities, usually larger and less isolated, referrals came quite quickly. The key factor was the effort of the system-based facilitator to make colleagues aware of the volunteers as an available resource. Facilitators themselves did the "matching" of volunteer with client and provided on-going consultation. For some facilitators, the measure of success was in seeing the time they invested in the training pay off in this way. Added to this was the growth in competence and self-esteem they witnessed among their volunteers.

The referral phase was part of the original conceptualization of the project. We now realize that "referral", "screening" and "liability" were concepts with professional connotations which did not fit this project. With hindsight, it was a mistake to set up volunteers to expect referrals which may not be forthcoming and who may be disappointed as a result. This expectation was also the source of considerable anxiety on the part of facilitators about how to "screen out" volunteers they were unsure of.

We had set out to include community people in the helping process. As the project progressed, it became clear that this collaboration between the formal and informal sectors was based, not on the creation of an "auxiliary" of selected volunteer helpers but on a basic community development dynamic. Community mental health workers had become community developers, tapping into the capacity and motivation of their volunteers to help others. The extent to which the volunteers's new skills reverberate through their families and relationships cannot be

measured but is undoubtedly considerable. And it is clear that the personal satisfaction volunteers gained from taking the program was sufficient reason in itself for doing so.

On the basis of this learning, we decided to drop the expectation of formal referral from the future promotion of the program. Volunteers may still be asked to accept referrals at the discretion of the facilitator but the expectation and the need for screening are removed. The formal system can thus continue to use this valuable informal resource, but without setting people up for disappointment.

The associated question, would there be concerns about these same volunteers helping people informally in their communities, was easily answered. People make their own decisions about giving and receiving help, and were doing so long before "Building Helping Skills" came into being. At the very least we were confident that what volunteers learned from the program could do no harm.

Sustainability and Dissemination

It was clear that the program needed both human and financial resources to maintain the volunteer networks beyond the end of the project. First, the system-based facilitators played a key role in keeping their groups active, generating referrals, and providing consultation. Second, the availability of funds to cover travel and meeting costs (however modest) was essential to enable volunteers to participate in rural areas. The facilitators and the volunteers proved to be their own best advocates the originally sceptical counsellor who became convinced that maintenance of her group was not time-consuming and well worth the few hours per month required; the volunteer group that successfully lobbied their Community Board for funding to continue to meet with the people referred to them.

Although the creation of a formal referral resource had been a motivating objective in their participation, both Community Health Boards recognized the primary value of the informal capacity-building dimension of the project. At the end of the pilot, one board made a commitment of resources to sustain the existing groups and to deliver further volunteer training. More importantly, discussion in management circles contributed to future dissemination, particularly after the evaluation confirmed the success of the program. Reports on the Building Helping Skills Project from senior staff in the two pilot health regions interested other regional coordinators in introducing the program in their communities.

Following receipt of the evaluation, the Health Promotion Contribution Program granted an extension to the project to enable its expansion to other regions of the province. This gave us the opportunity to repeat Phase I, recruiting and training a new group of facilitators and incorporating the learning from the pilot project. With many questions clarified, Susan revised and condensed the training from twenty modules to fourteen. After the thorough testing of the manual by the first group of facilitators, she adjusted the Facilitator's Manual accordingly.

There was a definite need to promote the program more widely as it developed, to make the public and other service systems aware of the existence of this new resource. We issued media releases at strategic points: at the end of Phase II, when the volunteers had completed their training and were available within their communities, and at the end of Phase III, when they could talk about their use of their skills. We held an open house and news conference to announce the granting of the extension, which was attended by the Provincial Minister of Health and the Minister of Human Resources and Employment, both of whom made statements

applauding the program. At the open house, facilitators and volunteers mingled and talked with Community Health board members and representatives from many other agencies. All these factors helped to position us for effective dissemination.

This time, we had more applications than we could accommodate, and they came from a range of agencies and volunteer organizations. The trainer program was more intense, and was delivered in a seven-day period with a weekend break instead of in two separate weeks with a month's break. Participant evaluations confirmed the effective design and the remarkably powerful nature of the program. What was striking was the consistency of the process with a different group of people with different ideas, experiences and responses. Although the group dynamics were different and the groups generated somewhat different material, the same learning took place. A similar internal shift in understanding of the helping process occurred.

One significant change from the pilot project was that participants came to this round of training with clear ideas about how they would use it on return to their agencies. This showed the commitment of these agencies to implementing the program. Participants included community mental health workers who planned to work with volunteers and clients, public health nurses who planned to deliver the program to other rural nurses, and a prison social worker who expected to offer the training to prison guards. There was a general consensus there was no limit to the number of people who could benefit from the program.

Beyond the Project

The end of the pilot project in 1998 was in fact only the beginning. By that time, the project had trained 24 facilitators to deliver the program in their communities. Two years later, the Helping Skills Program continues to expand on two levels, reaching new geographical areas and new population groups.

CMHA formed a new committee to establish a structure for on-going delivery. The committee identified two levels of training: Level One (the Helping Skills Program for volunteers) and Level Two, the train-the-trainer program for facilitators. As the number of volunteers who graduated from Level One increased, it became clear that several of them were potential facilitators. CMHA offered a condensed facilitator training program to people with the necessary skills who had completed Level One. The original Level Two, the intensive six-day train-the-trainer program, continues to be the means to introduce the program to new geographic areas, both inside the province and beyond.

The provincial government has become an important partner in funding the expansion of the program to new populations. During 1999, the Department of Health and Community Services provided a grant to adapt the program for delivery to youth. The Consultant conducted facilitator training pilots with two groups composed of young people between the ages of 18 and 25 and some adults, with the goal of adults and young people co-facilitating the youth training. The content of the program and the facilitator's manual were revised to be developmentally appropriate for youth, and dissemination of the volume has just begun. The Victim Services Division of the Department of Justice has also funded facilitator training. We are now looking at introducing the program for use with workers in long-term care facilities.

The Level Two (facilitator) training involves a limited financial investment from governments and boards. The agency or organization to which the facilitator belongs manages the dissemination of the volunteer or "helper" training (Level One). CMHA retains control over the

delivery of Level Two. It is tracking dissemination of the program by issuing certificates to those who take the Level One and is maintaining a data base and evaluation records. According to the evaluation forms and requests for certificates of completion that participants continue to return, the program has now reached hundreds of people.

The evaluations confirm the freshness and power of the program. They also confirm that the program enables people to develop very useful skills and builds their sense of competence and self-esteem. As the project evaluator said in her final report, "Helping Skills is a very powerful mental health program. It is a means to deliver a mental health program to individuals and avoid the stigma that mental health services often have."

Conclusion

In setting out to return the skills of helping to the community and develop an area which people could build some sense of control, CMHA learned some lessons about the practice of inclusion.

1. The people involved must identify the **barrier** or need. The Community Needs Assessment Project served this purpose in this project.

2. An investment of **resources**, both human and financial, is essential, and those who hold the resources must equally recognize the barrier or need. This program could not have been developed without the collaboration of the Community Health Boards, their investment of staff time, and the financial support of HPCP. These provided the resources and skills through which the process of skill transfer to the community could happen.

3. Despite a well-recognized need, this process required a **catalyst**. CMHA fulfilled this role along with the expert consultant.

4. The process of **participation** was an incremental and evolving one. It started at the community level, with people identifying their needs. It then moved through the development of an idea by a voluntary organization (CMHA), negotiation with government investors (HCPC and Community Health), and engagement of the facilitators who were to bring the process back to the community. At each stage there was a feedback loop to check that we were working in congruence, and the program that emerged reflected the involvement of all the partners.

5. The result is people in communities taking **ownership** of their own skills and becoming their own resource.

The potency of a program like this depends on the degree to which it is congruent with real community dynamics which a project can catalyse. The Helping Skills Program is effective because it taps into a powerful community dynamic, the motivation of people to help others. It has genuinely broken new ground in returning to the community skills that are usually seen as the preserve of professionals, and in opening up an area of collaboration between formal and informal resources. Most of all, it has defined a process of human learning and skill development which reverberates through the lives and relationships of participants and builds community capacity in the most fundamental way. The program demonstrates inclusion in every sense of the word.