

National Evaluation of the Community Development Workers

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March 2011

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Acknowledgements

The research team extend warm thanks to the staff in each of the four case-study areas for their helpful and swift co-operation with this evaluation. We also wish to thank all participants for giving their time to be interviewed and the respondents for completing our online survey. We are grateful to our colleagues at De Montfort University (DMU), especially Nicola Smorowski and Sarah Allen for expert transcription services and to Joanne Drury for effective administrative support. In addition, the research team wish to thank Hari Sewell, Melba Wilson and Christine Savage for dedicated project liaison.

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Section 1: Introduction and Context

The relationship between Black and Minority Ethnic (BME) communities and mental health services has long been marred by discrimination and inequality. Set within a wider context of cross-cultural stigma around mental health problems, BME groups also often face entrenched difficulties both within their communities and in their relationship with services. The arguments are generally well known: some BME groups are over-represented in services; other groups do not have adequate or appropriate access. Fitch et al (2010) neatly summarise four key barriers that BME groups may face in relation to mental health. These are:

“Sociocultural difficulties (health beliefs and mistrust of services), systemic problems (lack of culturally competent practices in mental health services), economic issues, and individual barriers (denial of mental health problems)”.

(Fitch et al 2010: 4)

Delivering Race Equality in Mental Health Care (DRE) was published by the Department of Health in 2005 as part of the response to the death of David Bennett in a medium secure unit. It set out to improve ‘equality of access, experience and outcomes for BME mental health service users’ (DoH 2005: 3). DRE comprised three ‘building blocks’ upon which the action plan would be implemented:

1. **More appropriate and responsive services** – achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups, such as older people, asylum seekers and refugees, and children;
2. **Community engagement** – delivered through healthier communities and by action to engage communities in planning services, supported by 500 new Community Development Workers; and
3. **Better information** – from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services. This will include a new regular census of mental health patients.

(DoH 2005: 3)

A recent review has been published that charts the progress of the DRE against these three building blocks (Wilson 2010). This current evaluation report concerns the second of these: the introduction of new Community Development Workers (CDWs) tasked with strengthening community engagement. The recognition of the potential value of using CDWs was captured in the original DRE plan:

“Any initiative aimed at improving the healthcare experience of BME groups must recognise the leading role that BME communities themselves can play...All communities have a role in preventing mental health problems and providing an environment where people who have become ill can recover and prosper.”

(DoH 2005: 59)

Funding (£5 million in 2004-05, rising to £16.3 million in 2005/06 and each year afterwards¹) was made available to PCTs to employ 500 CDWs: the only hard target associated with the DRE.

1.1 What is community development work?

Community development work is a value-based process which aims to achieve social justice and equality through engagement with communities. It is a specific sub-set of a wider body of practices known as ‘community work’. Communities can be defined by their geography (local neighbourhoods or estates, for instance), their interests (collective concerns) or their collective identities (such as different BME groups). More often than not, these three definitions of community intersect. Essentially, the process of community development work enables people to work collectively to:

- Identify their own needs and aspirations;
- Take action to exert influence on the decisions which affect their lives

¹ See Wilson (2010: 28)

- Improve the quality of their own lives, the communities in which they live, and societies of which they are a part.

(LLUK undated: 4)

The values that underpin community development work include commitments to equality and anti-discrimination, social justice, collective action through community empowerment and working and learning together (See LLUK undated: 7-9). At the heart of these values is the recognition that inequality exists and should be rejected and challenged:

“The [community development] process is educational. It is about people in communities creating opportunities for growth and change and deliberate movement towards the ends which they determine and in process of doing so increase their critical awareness, knowledge, skills and attitudes.”

(PCEO 1992: 7)

In the context of the DRE, Community Development Workers were employed to apply these principles and processes to challenge race inequality in the context of mental health. At the outset, it was recognised that the role of the CDW would be regionally (and, as this evaluation shows, locally) determined but four key functions were identified:

- To bring about changes to the way that services were commissioned, delivered and perceived. This included identifying gaps in services, improving mental health needs assessments and improving communication between BME community services and statutory services;
- To identify and remove barriers to accessing services;
- To improve services and develop joint working between statutory and community services; and
- To work with BME communities to help develop grass roots solutions and community resources for mental health. They also helped to build relationships with local groups and networks so that they could have a more effective role within local partnerships. (Wilson 2010: 28)

1.2 This evaluation

De Montfort University (DMU) was commissioned by the National Mental Health Development Unit (NMH DU) in December 2010 to undertake an evaluation of the Community Development Workers nationally. DMU has a long-standing commitment to teaching, learning, research and development in the two interlocking areas of this programme: community development and mental health service provision.

The evaluation employed a multi-modal approach to data collection, verification and analysis that enabled investigation of both breadth and depth. Two main stages of data collection informed the evaluation and these are discussed below.

1.2.1 Phase one: national online survey of CDWs

An online survey was designed to capture the perceptions and experience of CDWs nationally. The survey employed a mixed method integrative design (Tashakkori and Taylor 2008) which provided opportunities for open responses to questions, judgements in terms of ranking and rating and an assessment of attitudes in response to key statements devised by the research team. The key areas explored by the research team included:

- Information about, and perceptions of, the CDW role
- Management, support and role development
- Engagement with other agencies
- Community participation
- Perceptions about the impact of the work.

A link to the national survey was sent by email to 423 CDWs listed as contacts on the NMH DU database (as of December 2010)². Three reminders were sent to respondents and the final number of completed surveys was 56. However, the research team received 156 'out of office' replies in response to the first wave of the questionnaire, 138 of which

² Note: approximately 18 of which are line managers of CDWs.

indicated that respondents had left their post at the time of the evaluation commencing or were invalid emails on account of not being recognised in the organisation.

1.2.2 Phase two: case-study visits

The research team supplemented the findings of the national survey with visits to four 'specific sites of interest' to further explore questions of impact with different stakeholders involved in the programme. These sites self selected their involvement, and identified an interest and capability to host interviews. The sites represented differing types of organisational structures in which CDW have worked, and are working. The case-study visits explored:

- Evidence of the types of local impact of the CDW role from a range of perspectives.
- Different perspectives on the contribution of the role to addressing inequality.
- The extent to which the CDW has increased the voice and influence of different community groups.
- Whether strategic and operational links with organisations and other stakeholders have enhanced the work.

Qualitative interviews were the primary method used during case-study visits and were semi-structured in format, driven by a preliminary analysis of the questionnaire survey data together with the objectives of the evaluation. Other approaches to data collection included observation of community events, a limited review of written documentation, focus groups and informal discussions with service-users. 34 CDWs, managers and stakeholders were interviewed in this phase of the study.

1.2.3 Supplementary fieldwork

The research team undertook supplementary fieldwork in the form of interviews with two NMHDU staff; a discussion on tentative findings and recommendations with 6 CDWs in the

national network; interviews with two regional co-ordinators and; a review of evaluation and case-study reports.

1.2.4 Ethical standards

All research conducted by De Montfort University is subject to ethical standards monitored by the ethics committee. Members of the research team also adhere to ethical codes set out by the British Sociological Association and the National Social Care Research Ethics Committee. Voluntary participation was emphasised throughout and informed consent was sought from all participants. The case-study areas have been anonymised in this report and are referred to throughout as A, B, C and D and we have avoided attributing quotations to identified individuals.

1.2.5 Limitations

This evaluation was constrained by the short timescale and limited resources and the findings are not designed to be generalised or representative of all practice. They do however provide important insights into the development and contribution of the CDWs nationally and in four areas.

In addition, our capacity to capture the positive work of CDWs has been undermined by the current financial context. Many practitioners have lost their jobs during the evaluation timeline and some services have been restructured. Evidence of this rapid change was seen in the survey non-respondents and in two of the originally proposed case-study areas being unable to accommodate an evaluation team.

Despite the best efforts of the case-study areas, the number of service users available for in-depth interviews was very small. The research team worked around this by observing mental health awareness events and engaging in informal conversations with larger numbers of service-users and community groups.

1.3 Structure of the report

This report contains a further five sections and is presented in thematic form. In **section two**, the CDW role is explored through an investigation of how the role is perceived, how it was implemented and what structures were in place to ensure its effectiveness. In **section three**, the contribution of the CDWs is reviewed by focusing on three key strands of work. In **section four**, specific focus is given to tackling discrimination and stigma. Finally, **section five** presents a conclusion in the form of critical success factors and recommendations for policy and practice. Summaries of key findings are offered throughout the report.

Section 2: The CDW Role

There are four thematic functions that have been the basis on which the CDW role has been implemented and developed. These functions, although clear as a policy agenda, have sometimes been problematic when translated into action. This is partly due to the nature of the competing demands, and the level of particular emphasis placed upon each function by CDWs.

A degree of flexibility in role definition enables local interpretation. One positive interpretation is that priorities are agreed at the most local of levels, enabling localised assessment of communities who are deemed to be most in need to receive a priority response. Conversely, without strategic objectives and commissioning priorities in place, CDWs have utilised their own networks, background, ethnic origin and personal contacts gained outside the role to establish workload priorities and to dictate their activity, leading to some communities slipping through the net because they are perceived as harder to reach or too difficult to engage. The four thematic functions of the CDW and interpretations of what they imply are set out below:

Change Agent:

- To improve communication between BME community services and statutory services and levels of understanding of the mental health needs of BME communities
- To identify gaps in service provision
- To improve the quality of mental health needs assessment for BME communities
- To work towards more inclusive commissioning of mainstream services and more effective commissioning of services for BME population groups

Access Facilitator:

- To identify and help to resolve access barriers for BME population groups at service design and delivery levels, and in BME uptake of services working with the IAPT agenda.

Service Developer:

- To promote services responsiveness to the needs of BME population groups and to develop more effective services for them
- To develop joint working between statutory and community services
- To help to evaluate and sustain improvements in service provision.

Community Capacity-Builder:

- To help BME communities to develop local solutions to mental health issues
- To support the development of BME community resources for mental health
- To help local groups and networks to develop the relationships and know-how which will enable them to make their views known and play an effective role in local partnerships for mental health.

The questionnaire provided qualitative data about the CDW role. When responses were coded, a considerable variability emerged in the participants' perceptions of their role. 56 CDWs responded to this question. The most common response category (Improve services/adapt services to communities' needs/address gaps in provision for communities) was mentioned only 26 times (less than 50% of respondents). Overall 19 different categories were created to cover the variety of responses (some CDWs gave responses in more than one category due to the open nature of the question). Only six other categories of response were mentioned by 25% or more of respondents: Challenge discrimination/reduce inequalities in experiences of MH services (20), Promote mental well-being (17), Raise awareness of communities needs and available services (16), Build bridges between services and communities (14), Address the stigma of MH issues in specific communities (14), and Improve communities' access to services/address barriers to access (12).

There appears to be a multitude of differing interpretations regarding role expectation with no agreed role descriptor, person specification or standardised objectives aside from delivering the DRE agenda and the four function themes. This simple factor whilst on one hand has prompted creativity, has, on the other, generated some degree of confusion,

hesitation and deviation, sometimes relying on the personal interest of the CDW but also in some cases, on the basis of local needs assessments.

2.1 Role definition

The most common issues identified in the questionnaire were grouped under 'role definition and recognition': difficulties that were linked to how the CDW role was prioritised, applied and valued in different areas. This was sometimes cited as a problem with how the CDW was valued by others, for instance:

'Managers of services have not seen the value in the work and have prevented staff from attending training... [due to] a small BME population in [the area] they think there is no need to deliver a different type of service.' (12, 3)

'I feel that management, the organisation has not been clear or had the knowledge of what the role was supposed to be...no clear guidelines to workers or recognition.' (12, 33)

The same worker described taking on DRE responsibilities to 'make up the deficit on a temporary basis' on top of their current generic responsibilities. Another respondent indicated that both managers and CDWs misunderstood their role (12, 5). Some respondents indicated that this was resolved as the role developed. One respondent felt their 'role has 'grown' with the job' (12, 8), another indicated that perceptions of the role had improved with 'community contact' (12, 5).

As identified elsewhere in this report, the balance between a 'strategic' role and one which focuses on community development practice was often difficult to manage effectively. One participant felt the CDW role 'went beyond the remit of a community development model approach' (12, 13). It was observed by the evaluation team that there were two consequences; either a priority was given to face-to-face community engagement or strategic influence. Some comments seem to reflect this:

'We have made significant progress with improving awareness with communities but have struggled to influence strategic changes.' (12, 19)

'[The] strategic element of the role was lost in the process of delivery. CDW appeared to be set to deliver a bottom up approach with no clear path for top down delivery which institutions needs in order to effect changes in service delivery' (12, 22)

For one respondent, meeting the ambitions of the programme was not easy since the role of the CDW can seem isolated:

'At times, I feel so lonely, isolated and burnt out by just making the case to do what I was intended to do all along. People do not understand the role. Or some faint ignorance, so they don't have to do what is required. You have to keep explaining the rationale and need and they want you to prove the need all the time when this has already been done exhaustively...At times I have been demoralised and it has been a battle.' (12, 52)

There is an expectation that those entering into the world of Community Development Work should have an understanding of what the work entails. However, evidence exists to show that this was not always the case.

"I think one of the things is there is a lack of clarity within the CDW team because I don't feel that [our hosting organisation] have a clear idea of what the CDW role was going to be." (CDW, Area C)

To have no understanding of the role of a CDW would have an obvious effect. A lack of focus and direction could be expected, as too would be the inability to set meaningful targets in line with the perceived role. However, not all projects suffered the same fate.

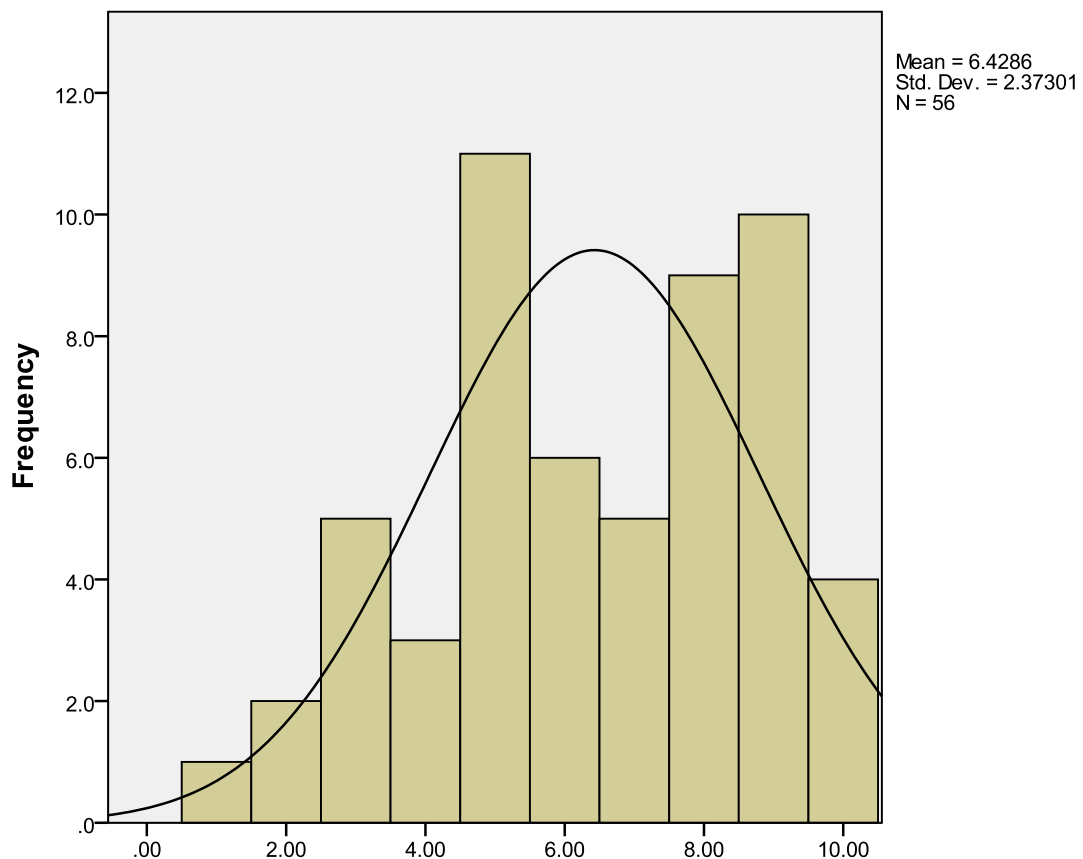
“The immediate management structure understands the relevance and importance of the role. I have always been able to work on projects with the full support of my employers.” (20, 10)

Having knowledge and understanding did not guarantee a good outcome in terms of support for CDWs. Many of those surveyed talked extensively about their line managers. Some were extremely positive about what managers offered but many were very critical.

2.2 Views on line management and support for the role

As figure 1 (below) demonstrates, there was some variability on whether management structures support the role of the CDW. Support for the statement that management structures support the CDW role is reasonably high on average (mean 6.4), but there were 22 responses rated 5 out of 10 and below, which indicates some cause for concern.

Figure 1 - How well managers support the role



Positive ratings of line management structures in the national survey seemed to be connected to the extent to which managers understood and supported the CDW role. One interviewee received ‘very good support from line manager...’ (20 6, 1) and another stated that:

“My manager has experience of community cohesion work as well as experience of working with community groups. This makes it easier as she understands what I am trying to do and is supportive.” (20 2, 2)

Line managers who understood and valued the role of CDWs were identified by the research team as a ‘critical success factor’ in the successful implementation of the programme. In one case study area (B), a ‘magic triangle’ relationship had developed between the commissioner, the manager and the CDW ensuring that the practitioner’s efforts were supported by those directing the work. As the CDW said: *‘[I have] an excellent commissioner and a great manager and that’s my rock’*.

Unfortunately, for most survey respondents and in some of our interviews, line management was less positive.

“I personally feel that management has been extremely poor, therefore other organisations are not going to value you if your own organisation does not...” (20 4, 7)

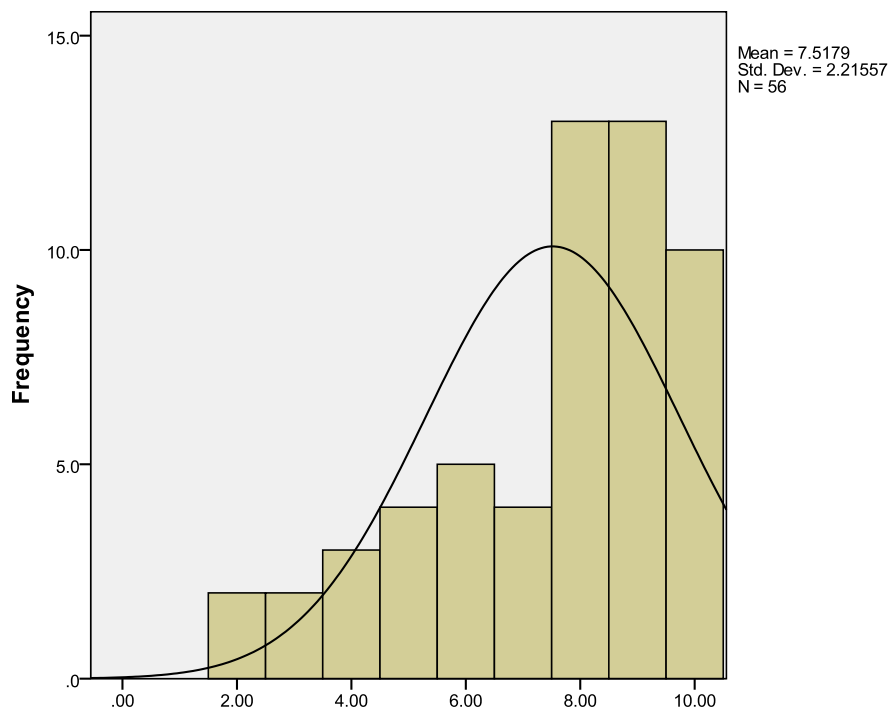
Although this feeling of poor management was echoed by many, some CDWs were able to understand the dilemmas that some line managers faced whilst attempting to carry out their duties. These were often related to aspects of workload and time together with higher levels of support (e.g. from the local Trust) as these comments illustrate:

“My line manager manages maybe a dozen people so isn’t really free to handle daily or weekly issues, only big ones.” (20 1, 4)

“My manager is very supportive but he does not get much support from within the Trust.” (20 4, 1)

For some projects, particularly those where there were substantive numbers of people in CDW roles, peer support was seen as critical. Survey respondents were largely positive about the opportunities they had to discuss the CDW role with others (see figure 2 below):

Figure 2 - The extent to which CDWs have discussed their role with others



Monthly meetings, supervision and an ‘open door policy’ allowed workers to offload and seek support on a frequent basis. The monthly meetings in particular were used in Area A to explore work being undertaken by CDWs. In one particular instance, workers would spend a whole day together as a team sharing professional experiences. Workers were given the opportunity to:

“Talk about (their) project, any issues, difficulties and the good things and the good practices.” (CDW, Area A)

This approach to work proved beneficial for this team but as seen through interview and case studies, not all projects were built around teams. For instance, in Area B, the CDW was a lone practitioner who had limited opportunities to engage with other CDWs. The CDW had accessed numerous alternative forms of support by developing effective working relationships with partners and through continuous engagement with her proactive commissioner and manager.

2.2.1 National support for the role

NMHDU and predecessor bodies ran a national network for CDWs, meeting on average four times a year. The network supported a regional structure. Chairs of regional networks attended the national network and brought information on behalf of their colleagues and information was also cascaded through this route.

CDWs were aware that a national organisation existed that could offer support but very few people accessed it and used it to its full potential. Some, however, were not familiar with the setup nationally, but these tended to be new members of staff who had just come on board.

Where individuals have been able to tap into national networks, it has proved beneficial. When asked directly about whether any national training had been accessed, the following response was obtained:

“National level I would say, the two that I have mentioned (conference on GP Consortia plus 1 other not identified) and then several conferences. We have had seminars like ‘The Big Society.’ There was one actually a fortnight agoAnd I’ve also attended a national level, a very high powered one in Nottingham actually it was on, IAPT (Improving Access to Psychological Therapies.)” (CDW, Area A).

Others had not engaged with their regional network:

“...at the beginning I was so keen to go (to meetings) and I was going to go but it would take me two hours to get there and then I would have the meeting and two hours to come back.” (CDW, Area B)

The practicalities of taking time out of ‘work,’ travelling and the costs involved prohibited CDWs accessing what can be seen as an essential service in providing support, information and training. This is not to say that CDWs did not recognise the benefits of accessing national or regional support as was identified by the same CDW:

“I would have benefited from the group if it was perhaps half an hour maximum travelling time to get to the meeting. You see you have to weigh up your priorities. It’s like I have got all these meetings, I have got to finish that report, at the same time can I really take a day off for this meeting. There must be some other system in place that you can tap into. (CDW, Area B)

The other issue contributing to the problem of accessing support and training was workload. However, being the only CDW around in this geographical area only exacerbates the problem.

Funding was another issue that prevented CDWs accessing national training and support. For example, to gain entrance to the conference on GP Consortia (from CDW4 above) cost £400. From conversations throughout the research period this statement was not atypical. Many CDW projects are based within the voluntary sector where finances are limited, possibly more so than those in the statutory sector.

Not everyone was aware of what the support networks exist but they did know what should be in place for CDWs:

“I have no involvement with any of it at all.....I think the networking with other CDWs hasn’t been as good as it should have been.” (Manager, Area B)

There was recognition that networking was important and should form an integral part of a CDW's working life but considerable differences emerged across the case-study areas in terms of equality of access to these networks.

Several mechanisms have been identified that CDWs were able to access for support. Mechanisms range from line management and peer support, training, attending conferences, adequate resourcing, funding and so on. However not all CDW projects are able to access what was rightfully theirs. Consequently some projects seemed more 'settled' and 'stable' than others. Many had attempted to succeed as they had expressed themselves passionately about doing the work they have employed to do. But, as identified throughout, there were barriers and these have prevented others from succeeding. For many the barriers are beyond their ability to control.

2.3 Working in partnership

Working links were generally strong, but particularly so with the CDW's direct employing organisation, and with VSOs. Links with mental health providers and the PCT (where not the employer) were generally satisfactory (mean 6.2 and 6.1, respectively), but with higher SD, and including 9 responses for each of 4 or lower out of 10. The list of statutory and voluntary agencies that CDWs have worked with to deliver their services is extensive ranging from small charitable organisations to large local authority departments. Many CDWs were actively involved in multi-agency responses to mental health needs in the local communities.

Considering the brief that CDWs were given, it would be correct to assume that any work would be carried out would require the involvement or support of other agencies, statutory or otherwise. Where these links were problematic, evidence from the evaluation indicates that there were some common difficulties related to differing agency understanding/agendas and limited or no engagement with CDWs:

“We had little or no contact with our PCT and found it very difficult to make contact with mental health service providers. So much so, we had to use a Social Inclusion Director contact.....to lend weight to our initial contact...” (20, 3)

“Mental Health Trusts have generally been very negative towards the programme. They have not allowed access to inpatients or others who use their service and would only very very rarely (may be once or twice) make referrals to our team so we have not been able to work with many ‘service users.’” (20, 8)

As to why other related organisations should choose to opt out are not always clear, but some projects did proffer some suggestions as to why this might be.

“They did not appreciate what they saw to be a segregated approach.” (20, 8)

When it comes to working with specific groups, such as those identified as BME, some organisations recognised as key agencies within the work of the CDWs had distanced themselves. There was a conflict of understanding and acceptance and in one case, a Mental Health Trust was perceived to hold an opinion that was detrimental to the work of the CDW and could be considered prejudiced. Their belief was that money spent on working with BME communities work was not valid and financially pointless due to the small numbers of people fitting into BME groups.

Another reason for opting out of partnership work was based on the inflexibility of the partnership organisation. CDWs would need to be flexible in their approach to work as they attempted to engage BME communities. Although CDWs would set targets for themselves, they would be based on their contact with the community and reflect the stages they were at and consequently remain fluid.

The implementation guide for CDWs indicates a clear commitment to partnership working but indicates rightly that public bodies need to:

“Be prepared to change their ‘normal’ way of involving the public in consultation exercises. They need to move to a much more participative and empowering approach based on flexible liaison, active listening and a willingness to learn from the experiences that communities bring to the debate, including critical feedback and scepticism from some quarters.” (Draft CDW Implementation Guide)

The call for flexibility can be challenging for organisations such as the NHS which as one respondent identified ‘is very hierarchical and is very much based on the medical model.....the targets that are set are not to be altered or deviated from....’ (20, 2). Some of these tensions were overcome by the CDW in Area B who had managed to work effectively with the local NHS Trust by ensuring regular access to the director and by working in partnership with an NHS community engagement worker. The community engagement worker felt that the role of the CDW had been vital in strengthening how the NHS understands different communities:

“my point to you is that clinicians themselves don’t actually get any education around this, they don’t...I don’t think it’s arrogance, if there is nothing in a space there, there is nothing in a space and I hope you understand that...The reality of it again is when you have got vast amounts of things you are trying to do all at the same time, something somewhere along the line is going to get missed... So it’s not just about communities it works both ways, if we are teaching this to our service users and carers and faith leaders then lets teach it to the staff.” (NHS stakeholder, Area B)

Despite some difficulties with partnership working, there was also evidence of progressive and productive relationships.

“Our working relationship with the local MIND is excellent.” (20 1, 1)

“I do feel that CDWs are more understood from the voluntary sector and the people and projects we work with.” (20 1, 2)

“The relationship with the voluntary sector has improved over time. (20 4, 8)

“It has been a real challenge to work with the statutory services as we are based in the voluntary sector.” (20 6, 5)

It takes little imagination to realise that those working in related fields within the voluntary sector appear to respond better to the working practices of CDWs. However, there was also evidence of strong praise for statutory sector partners from the voluntary sector as in Areas A and B, summed up in this quote from a questionnaire respondent:

“I think NHS is very supportive of the role and has direct links to those commissioning the service. The directorate we were originally based in was commissioning, which I feel gave our team great insight into the way we needed to approach the role and has resulted in real change for BME communities on our patch.” (20 3, 4)

2.4 Background of the CDWs

CDWs came from a range of different backgrounds with survey respondents indicating the most common professional backgrounds were in mental health (30%), social work (9%) and youth and community work (32%). Where CDWs have attempted to engage with communities that they do not originate from, both culture and language issues have hampered their work:

“The language is also a barrier because although I can speak different Asian languages I can’t speak Polish or Chinese so I have to depend on interpreters and it’s sometimes quite difficult in a group.” (CDW, Area C)

2.5 Current opportunities and risks for CDWs

The majority of respondents indicated that their job was currently 'at risk' at the time of completing the survey (64%). In addition to this data, we received 138 'out of office' returns who had already left their post as of December 2010 or whose emails were no longer valid.

The opportunities for CDWs to develop their careers within mental health community development, seems to have been stifled by the limited chances for promotion. Within the role there seems to be two grades, a Community Development Worker and a Senior Community Development Worker. Senior CDWs were often in situ prior to the appointment of CDWs and in many examples remained in post for the duration of the funding. The lack of career pathway seems to emanate from the Department of Health Final Handbook which suggested that:

“Whatever career path or progression a CDW might choose, they need to be committed to and take personal responsibility for their own continuing personal development that should include supervision and annual appraisal. The world of health and social care is dynamic, and CDW must fully embrace such change and diversity based on continually up-dating their knowledge and skills.” (DH 2006 p47)

Workers participated in supervision and annual appraisal but limited resources aside from salary payments placed the responsibility for CPD (including both time and funding), upon the individual worker with varying outcomes. Furthermore, the short term nature of contracts engendered anxiety within workers who were mindful of the lack of permanency to their role, and despite enthusiasm for it, adopted stance akin to others who find their jobs are at risk and actively sought more permanent jobs both within and outside the sector.

2.6 Key findings:

- There was considerable variation in how CDWs defined their role, and these definitions were often shaped by local circumstances and the CDW's own background and priorities.
- The balance between a 'strategic' role and one which focuses on community development practice was often difficult to manage effectively.

- Positive ratings of line management structures in the national survey seemed to be connected to the extent to which managers understood and supported the CDW role. This was further strengthened where relationships with commissioners were strongest.
- There was some variation in the extent to which CDWs accessed regional and national networks of support. CDWs also used a range of other mechanisms to gain support for their role including line management and peer support, training and attending conferences (where funding permitted).
- Partnerships were formed with a range of statutory and voluntary organisations which were perceived by CDWs to be positive. Factors that hindered good working links included misunderstandings of the CDW role
- There was evidence that the CDWs had brought new understanding to organisations on how to engage effectively with different communities.
- The majority of survey respondents indicated that their job was currently 'at risk' and this has led to a reduction in CDW numbers.

Section 3: The Work of CDWs

There was evidence throughout the evaluation of creative, innovative and meaningful work with community groups and with a range of statutory and voluntary agencies. CDWs had undertaken numerous activities ranging from one-off activities of a high profile nature through to sustained work with small groups over a longer period of time. This section of the report examines some of the key work of CDWs, drawing on survey data and our case-study visits.

Survey respondents were asked to describe the types of work they had undertaken. The majority of respondents (96%, n=54) had undertaken work that had sought to raise awareness of mental health issues and services in the community with the same number also raising awareness of BME needs and issues within services. All but one of the respondents had indicated they had undertaken an 'information giving' and 'signposting' role. 91% of respondents (n=51) had also provided some kind of training. Respondents were asked to provide examples of their work as illustrations and the list offered was extensive. Examples of this work are now discussed.

3.1 Raising awareness in the community

Information and awareness raising activities ranged from the hosting of different events through to the development of community packs and information that people could use beyond their contact with the CDW. This work was often linked to overarching events (such as World Mental Health Day or International Day of Women); others were initiated by the CDW in consultation with the community or with partners. Examples included:

- Several respondents described undertaking work tied into World Mental Health Day which included conferences, public information events and a wide range of creative activities. Much of this work was about strengthening the link between BME

perspectives and mental health (for example, a stage play drawing on an African perspective of mental health).

- There were examples of building a mental health dimension into cultural events such as the inclusion of wellbeing events incorporated into gypsy traveller history month and the organisation of annual black history month events around the theme of mental health. This enabled practitioners to access existing and well established cultural celebrations to promote mental wellbeing.
- There was also evidence of newly established culturally specific events such the forming of a refugee week event for the first time in Swindon which attracted attendance from over 500 people.
- Specific work was done to raise awareness about cultural practices that may be linked to mental health problems, such as work done with the Somali community about the detrimental effects of chewing 'KHAT'.
- Regular events (such as the Cook and Meet group in one of the case study areas) provided an ongoing opportunity for the CDWs to raise awareness in an informal setting and with recognition to cultural needs.
- Working in partnership with other organisations enabled CDWs to draw together interconnecting themes in their work. For example, partnership work with a local museum and the African Caribbean Centre resulted in designing culturally specific activities to explore women's mental health and wellbeing in the context of the International Day of Women for two years in a row.
- Working through established groups was also identified such as providing health and wellbeing awareness sessions to ESOL classes.

It was common practice amongst for participants to identify mental health promotion as more than prevention strategies alone. Health promotion is more subtle and should focus on aspects of wellbeing, not necessarily disease. In keeping with this definition, some of the work that the CDWs delivered was more aligned with promoting wellbeing in a more general sense which was intended to reduce the need to access services. Examples included the introduction of creative activities and performing arts such as an African dance group linked to a drop-in centre and several arts projects in the community. One respondent had

secured funding to continue a basic language project that enabled people to feel less isolated and depressed. Another had introduced:

“Movers and Shakers [a programme which] engaged isolated and socially disadvantaged communities (Asian, Caribbean and Chinese), encouraging them to lead healthy lifestyles. Physical, mental and creative activities, healthy lunches are part of the weekly programme to deliver a much improved awareness of self help.”
(27, 20)

The organiser of wellbeing awareness session to ESOL classes acknowledged the point that to challenge raise awareness and challenge stigma required a ‘subtle’ approach as people ‘simply do not want to attend events or sessions which overtly tackle MH as the level of stigma is so high to start with’ (31, 45).

In addition, much work was undertaken to strengthen the capacity of local community groups and this work often addressed the different goals of the CDW programme. This was most effective where service users and community groups had received training and support to deliver peer advice on health. Two key examples illustrate this:

- “Wellbeing for Travellers is a joint partnership initiative where women and young girls were trained (practical based learning) to become community health advocates, benefitting 60 families in [the area]. Phase 2 entails a health needs assessment, conducted by the trainees to determine local needs”. (27,20)
- “Organised cultural competence and leadership training for Lambeth BME Service Users [and] assisted in the creation of Service User lead group”. (27, 33)

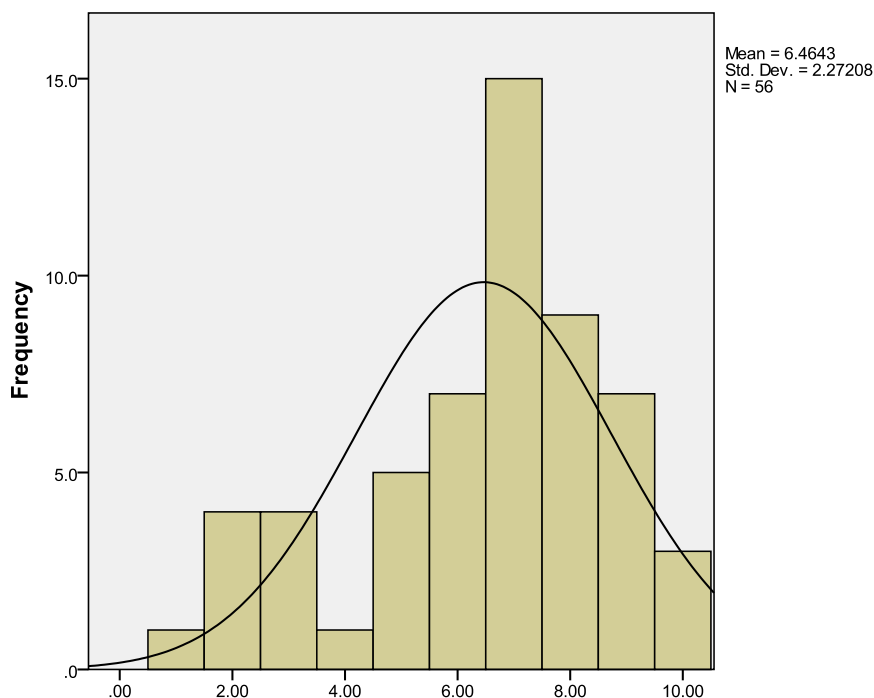
Interestingly, the views around community participation indicate that most respondents felt participation was not fully meaningful. However, these examples indicate some effective strategies to include service users in leading on peer education and awareness raising initiatives.

3.2 Engaging service users and the wider community

Engagement with service users and the wider community was seen as a key role for CDWs. Despite local variations in practice and purpose, strengthening community participation and providing representation for service users were two founding principles underpinning the role on its inception.

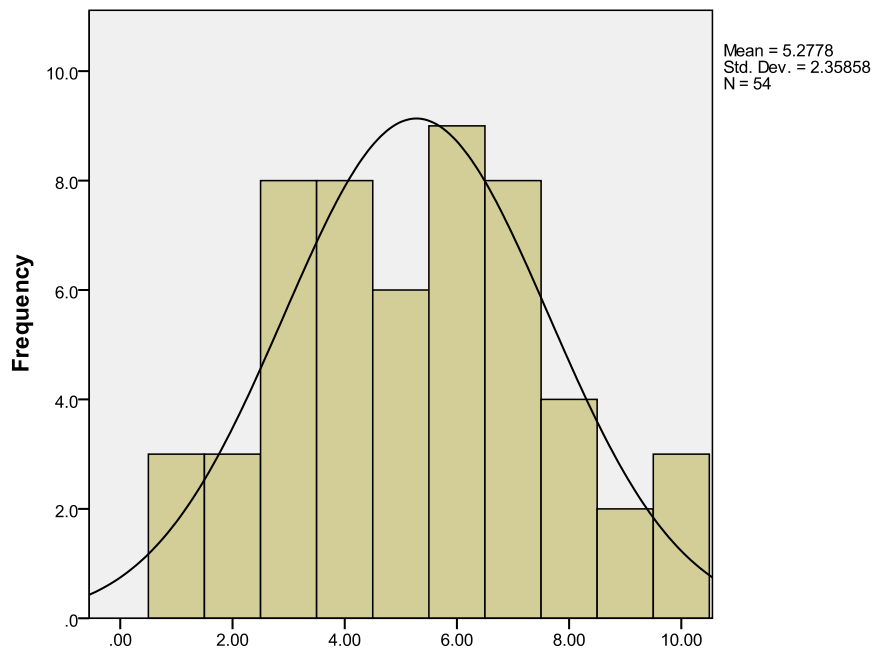
There were mixed responses in the questionnaire survey when asked to assess the effectiveness of engagement with service users as figure 3 shows. Most people indicated a largely positive rating (7-10). However, there are a significant number of respondents who rated their engagement at 6 and below including some responses at the lower end of the scale (2-5).

Figure 3 - Success of role in engaging service users



Respondents were asked to rate how effectively they have been able to ensure the needs and views of local communities were reflected in service planning and commissioning. Perhaps unsurprisingly, there were mixed views with most respondents providing a rating between 3 and 7 (see next figure).

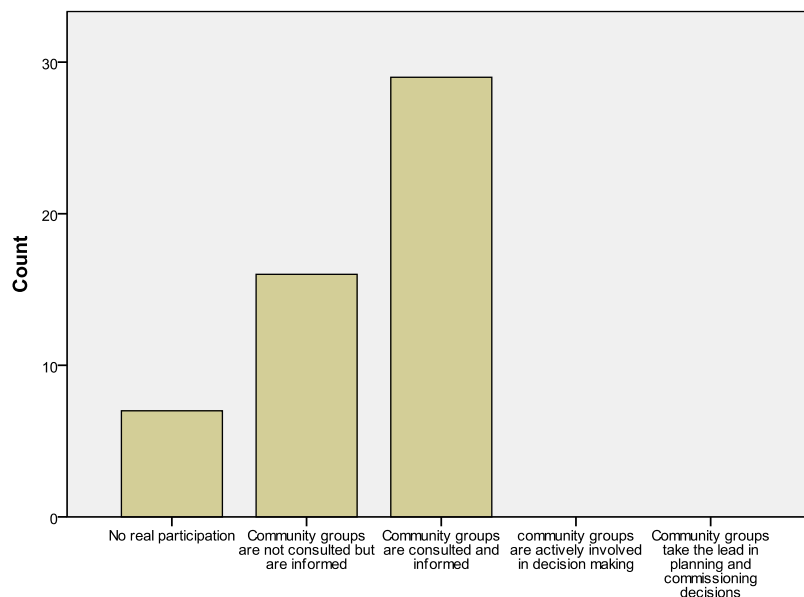
Figure 4 - Effectiveness of ensuring needs of local communities are represented



There was a generally slightly positive response to the question as to whether the role had ensured effective community participation (mean 6). Although there were 11 out of 50 responses of 4 or below out of 10 for this question, this was somewhat counter-balanced by 22 responses of 7 or higher.

However, it is telling that the responses to the question using terminology from the “participation ladder” told a rather less successful story (see figure 5 below).

Figure 5 - Overall assessment of level of community participation



Nobody indicated that the level of participation they had seen involved community groups being active in decision-making. 29 out of 52 responses to this question said that community groups were consulted and informed (though not apparently active in decision-making), but 25 indicated either no participation at all, or the rather tokenistic participation situation of groups merely being informed about planning decisions but not consulted.

3.3 Shaping services and influencing policy development

Respondents provided examples of raising awareness in services and there was again evidence of a range of approaches used by CDWs to support the development of service provision. Alongside raising awareness of the needs of BME communities, there was evidence of representing service user views, providing more effective needs assessments and ensuring that service development was specifically tailored to different groups.

Carrying out localised BME mental health needs assessments was seen as important since it not only helped the CDWs to target their work more effectively but it also provided data for local services to begin to be more responsive. As one respondent said 'the original ambitions [for the programme] were based on national stats...by adapting [these], more beneficial outcomes have so far been achieved locally' (12, 22).

In Area B for example, the first CDW in post prioritised research, identifying the different BME groups locally and setting out the specific service issues in relation to these groups. Through this process, different groups were 'made visible' and their needs were differentiated appropriately. Certain groups, for example, were overrepresented in mental health services whilst others were drastically underrepresented. The comprehensive local needs assessment ensured that the CDW did not attempt to use a 'one size fits all' approach (CDW, Area B). When the second CDW came into post, she worked to a thorough assessment and targeted her work effectively.

One respondent described the value of sharing good practice in relation to needs assessment. The CDW had visited another service and identified how they assessed needs. This led to the local service implementing 'best practice and equity of service provision for

groups such as Travellers' (27, 2). Another respondent had conducted a number of surveys of different groups to produce reports that influenced services with groups in prison and in the community (27, 45). Rightly, one CDW identified the need to assess cultural competence in NHS staff resulting in a clinical audit on the cultural sensitivity of the Trust (27, 49).

Raising cultural awareness amongst mental health services was identified as one way of ensuring the accurate representation of service user views. Key examples of this work included:

- The production of a handbooks and booklets that identified cultural practices and traditions as well as ways of working with different groups. For example, a guide entitled *“Working With sub-Saharan African Communities”* and a booklet entitled *“An Improved Path to A Better Road”* that explains Gypsy Traveller cultural practice for health practitioners. BME toolkits and other good practice guides were also developed by CDWs in consultation with service users.
- Presentations to staff at conferences and team meetings including one off events and on a more regular basis. Examples included: a CDW presentation at an age equality conference on elder mental health needs and challenges for the future; presentations at monthly clinician team meetings to inform services of the CDW role and work progress; delivering role presentations and raising awareness for forensic services staff;
- The implementation of service user feedback mechanisms designed to capture particularly the views of BME users and carers.

Effective work was also undertaken to encourage ways in which BME service users could talk about their experiences of services. For example, a respondent described organising a ‘Safe Space Event’ where BME patients could talk openly about the services they had received. Another respondent described setting up a Polish Association for Health Needs for new migrants from the Eastern Block. In Area B, a significant component of the film event had been the inclusion of a panel of NHS staff that answered questions about services and challenged both public and professional perceptions about the underrepresentation of this particular group.

Examples of specific service development were also identified in the survey. These included: the introduction of a BME mental health and disability organisation with a drop in service for the community; the development of a multicultural counselling service; and using the Direct Payments scheme to run a group for Asian service users where they have the choice to carry out activities which are culturally specific to fit in with the social inclusion and recovery agenda.

Whereas extensive examples were offered of raising awareness and to an extent the above examples show influence within organisations, there was less evidence of influencing policy development. This balance reflects the largely operational role of the CDW explored earlier in this report. Specific examples of policy influence or development were offered in some cases:

- Contribution to an emotional health and wellbeing strategy.
- Involvement in changes to the census for Gypsies and Travellers.
- Setting BME priorities in the joint strategic mental health plans in the city.
- The CDW featuring in other organisations' operational plans such as a partnership for mental health prevention and promotion to 16-25 year olds that relies on the CDW targeting BME young people.
- Setting up a multi-agency BME domestic violence group.
- Provided comment on new policies within organisations to ensure needs of BME service users and carers have been taken on board.
- Introducing a policy document on spirituality for the Trust.

As indicated 91% of respondents (n=51) had delivered training as part of their role. Some of this has been delivered in the local community to raise awareness or to strengthen peer education approaches (see above) but there was also evidence of delivering training to a range of mental health services. Examples included:

- Devising and delivering various forms of race equality and cultural capability training delivered to health and social care staff and NHS staff including front-line staff at GP surgeries and professionals from other agencies.
- Training on Ethnicity and Cultural Competence to trainee GPs at a University
- Mental Health First Aid training for Listeners in a prison.
- Seminars and training given to CMHTs, CHAMs, Prison Services, Probation Services, A&E, AMHPs, Community Cohesion Groups, National providers working with Gypsies and Travellers.
- Devised a training package for professionals on promoting equality and cultural competency

Whilst the list of specific policy influences seems short, it is important to see this in the context of the other work that CDWs have achieved. Policy itself does not necessarily lead to changes in service provision and as the examples in this section show, comprehensive needs assessments and the introduction of new services may themselves constitute a bigger impact on communities. There is little doubt that CDWs have been strongest in raising awareness in the community, building capacity and changing attitudes within services, reflecting the traditions of community development work. Less obvious is strategic policy influence but there are examples where assessments and good practice guides, partnership working and training have shaped how NHS staff engage with service users.

3.4 Key findings:

- The majority of CDWs had engaged in work that sought to raise awareness of mental health issues and services in the community as well as raising awareness of BME needs and issues within services.
- This work was delivered through: high profile events; building mental health awareness activities into existing community groups; establishing new groups and embedding mental health promotion into everyday practice.
- Much work was undertaken to strengthen the capacity of local community groups and this was at its strongest where service users and community groups had received training and support to deliver peer advice on health.

- There were mixed views on the effectiveness of engagement with service users and the extent to which respondents felt that they had been able to ensure the needs and views of local communities were reflected in service planning and commissioning. Nobody in the survey indicated that the level of participation they had seen involved community groups being active in decision-making.
- There was evidence of shaping services through the effective representation of service-user views, better local needs assessments, the production of handbooks and good practice toolkits, conference and meeting presentations and the implementation of service-user feedback mechanisms.
- CDWs have been strongest in raising awareness in the community, building capacity and changing attitudes within services, reflecting the traditions of community development work. Less obvious is strategic policy influence.

Section 4: Tackling Stigma and Discrimination

As the previous section illustrated, there was extensive evidence of raising awareness both within communities and in services to try and address embedded discrimination against BME groups. The challenge to tackle stigma and discrimination was central to the introduction of the CDWs and delivering the DRE principles in practice. Stigma and discrimination around mental health is deeply rooted in society and is cross-cultural. This study found that discrimination operated at three significant and interrelated levels and this invariably had an impact on approaches adopted by CDWs.

- Firstly, there was the **stigma found within communities** evidenced in the suspicion of community groups towards mental health services as well as often entrenched stigmatisation of people who experience mental health problems.
- Secondly, these groups, on account of their 'race' and socio-economic status, invariably experienced **racism** which CDWs had to have a sound responsiveness to.
- Thirdly, CDWs were required to challenge different **established institutional practices** that, at best, had not yet engaged effectively with groups and, at worst, had reinforced negative experiences of mental health service provision.

In sum, while the aim of challenging stigma and discrimination was at the heart of the CDW role, it proved to be a difficult endeavour.

There were fairly uniform and fairly positive responses to questions about the effectiveness of the CDW role in promoting equality in service delivery, challenging stigma and discrimination, and delivering a greater understanding of equality in service delivery. The mean response for all of these statements was between 6.7 (stigma) and 7.7 (understanding of equality), with only very small responses less than 5 out of 10. Belief in the effectiveness of the role in ensuring that service delivery reflects the needs and views of local communities was less well supported. Here the mean response was 5.3, and the SD was 2.4, with 22 out of 54 responses being 4 or less out of 10.

The majority of survey respondents (96%, n=54) indicated that they had undertaken work to challenge discrimination and stigma as part of their role. Many respondents acknowledged that there was still a 'long way to go' since discrimination is 'ingrained' and 'deeply rooted in communities' (31 4, 5). CDWs were presented with arguably the most difficult challenge: tackling the discrimination and stigma associated with mental health, the wider discrimination faced by BME communities and the problems of opening up access to services with sometimes entrenched discriminatory practices.

CDWs saw themselves as providing a vital role in challenging stigma and discrimination, challenging and supporting communities and services to work towards change:

"We have been described as the grit in the oyster and we have managed to engage people in courageous conversations regarding stigma" (31, 50).

"I feel most people have a better understanding of how to tackle stigma and discrimination and are able to challenge inequality in service delivery more freely" (31,48).

Personal and cultural views around mental health were manifested in a number of ways. Those experiencing mental health problems were described as 'possessed' or who were involved in 'black magic' (CDW, Area B). Family problems and upbringing were also described by CDWs as a common explanation for why someone would experience mental health problems. The net result was that people would be encouraged to 'keep away from' others who may be experiencing difficulties. One questionnaire respondent noted:

"Stigma and discrimination is even harder to address within BME communities and I believe the target audience for this is young people...as they often pass on language and new skills that they have learned to their parents in order to re-educate them." (31, 17)

What was reported as “cultural barriers” presented by “closed communities” such as some Eastern European groups, the Gypsy/Romany/Traveller communities and some sections of the South Asian population made these groups difficult to reach. This was explained by these groups being less likely to trust outsiders, and the ethnic origin of the CDW played a significant part in whether any intervention would be accepted. For example a CDW working with women from the Bangladeshi community suggested that if she were not of the same ethnic origin and gender there would be no chance of engagement on any level.

‘...professionals coming in doing sessions on healthy eating, sessions on stroke and things like that, how does healthy eating affect mental health and what is this about relaxation and how does it help. They just brush all those things off it’s probably because they are not so used to it or they have not been exposed to it’. (CDW SI 11)

‘I think that some of the Asian groups that we have worked with, it has worked really well. They have started to support each other and recognise things like post natal depression that previously would have been... she just doesn’t like her husband and she just doesn’t want to be married, but now once we’ve brought the awareness and brought the professionals in to talk, they have actually gone back and spoken to their family members and understood it much better.’ (CDW SI 12)

A BME Outreach Team was described by one project in which the workers operated in a proactive and even “assertive” manner in their efforts to attract and engage isolated individuals. One example of this relates to CDWs being creative in their quest to connect with individuals from a BME background and capitalising on legislation which requires that immigrants must show that they can speak and understand English if they are a non-European migrant or as the partner of a British citizen or a person settled here. English for Speakers of Other Languages (ESOL) courses are a mandatory process in the attainment of citizenship and CDWs have posted themselves where these courses occur in an attempt to engage with people. The use of interpreters was also identified in both the survey and within case-study areas including, in one case, the commissioning of interpreting services from a local Polish Community Association.

A consistent barrier to engagement was the question of how to reach isolated people when it was not known where exactly these hidden people are.

Involving the community and in particular community and faith leaders should not be underestimated.

‘I have worked together with the Trust’s Spiritual and Pastoral care team where we have given presentations at places of worship within the community and to patients within the mental health services.’ (20 2, 5)

Involving community and faith leaders and getting them ‘onside’ made it possible to reach communities that ordinarily would have remained distant. For example, the issue of mental health was raised in Area B amongst several groups of various faiths. Groups from the Hindu, Sikh, Christian and Muslim communities shared in a programme of events. Although the CDW was from a particular faith background, by involving Community and Faith Leaders, she was able to build up trust with various sections of the community. This method of working was highly recommended.

Provided over a period of six weeks (with one day per week attendance), the attendees comprised not only religious leaders but also committee members and other staff involved in religious and community meeting places. This led to the possibility of ‘cascading’ mental health knowledge to various community groups who found the advice of faith leaders to be more credible. The issue of credibility had posed a particular problem for Area C. The host organisation was perceived negatively by the local BME community which hindered efforts to work with community groups. The use of peer-education programmes and faith leaders ensured that issues of credibility were overcome. In Area A for example, partners from a health action charity reported positively on the CDW’s attendance at churches where African Caribbean communities met. She attended to give information to the congregation on what to do if there was a problem and this was positively received by the community members.

In Areas A and B (as well as other respondents in the survey), the importance of high quality training was cited as significant. Champions had all been trained and were effective at giving the right information and signposting to support services where the community development worker was not available or there were problems with credibility.

4.1 Barriers and problems

Respondents recognised that it was probably too early to judge the effectiveness of the CDW programme in measuring it against its original objectives especially in relation to redressing inequality. It was the most common theme identified in respondents' ratings of whether they had effectively challenged stigma and discrimination. Change was beginning to manifest in local areas, but:

“Work with service delivery is only now really taking off. Previously they were ticking boxes by seeing us. Now through quarterly Board meetings and [training] there is a lot more engagement and uptake by them. For the last 4 years the project has been trying to undertake stigma and discrimination work. Over time we have got better at engaging the community. There is still a long way to go” (31, 5)

Respondents also recognised the twin challenges of reducing mental health stigma and service discrimination, not helped by short-term targets and funding:

“[It is] a huge agenda and we cover a huge array of work, organisations etc. I think that stigma and discrimination will take a long time to go and often work to prevent and promote mental health is a long term objective and we live and work in a society which is geared up to short term work that is crisis driven” (31,17).

The comment about time was made more generally in relation to how far the CDW role had met its original ambitions. One respondent commented that ‘the ambitions were sound but the time given to them [was] insufficient’ (12, 37) and another said ‘the DRE was simply not given a long enough timescale to achieve its objectives in full’ (12, 34). These views reflected

a common concern about the relatively short timescale by which the effectiveness of the CDW programme can be measured.

Two respondents indicated that their role had been cut short and that they should have 'had the full five years to make a difference' (12, 2). For another, the ambitions for the role were clear but 'the hasty and last-minute recruitment process was flawed' (12, 15). Most recognised that role's commitment to reducing inequality was a longer-term project. The CDW in one of our case-study visits described the work as 'just beginning'. For the regional lead we interviewed, the role required practitioners to embed themselves in communities to build trusting relationships:

'The first three years, you work in a way that builds trust. You walk alongside people – say to people 'I know this team, this Social Worker; they won't do such and such to you'. It's a bridging role.'

(Regional Lead for CDWs)

Resource issues were also identified by CDWs in the survey. In relation to meeting the ambitions set out for the role, a number of resource factors impeded the work. Some of these issues were related to the lack of project funding in addition to the role:

'There are no resources to follow through any plans that we had with BME communities.' (12, 2)

'Funding of the roles was a key restrictive factor that hindered engagement, sustainability and outcome of projects. Socially disadvantaged such as the Traveller communities do not have money or means to engage effectively with service providers.' (12, 21)

Resource issues required creative working, evidence of which was seen in two of the case-study areas. In Area B, the CDW had engaged the local cinema in providing the venue and facilities for the screening of the film that she used to promote understanding about mental health problems. The 'Cook and Meet' programme in Area C was almost 'resource neutral':

participants themselves brought the food to the meetings. Questionnaire data also indicated that partnership working had enabled CDWs to develop good practice in spite of resource constraints. For example:

- Partnership with a local voluntary sector organisation and a PCT had enabled the CDW to access funding for capacity building within the BME sector (32, 1).
- Free physical activities for refugees and their families and safeguarding training for staff were secured in partnership with a local authority (32, 2).
- Working with the local football supporters' trust to develop a football club as a focal point for community activity (32, 13).

An issue related to resources was the relative status of the CDW compared to clinicians and other staff. During a case-study visit, the issue of pay and conditions was raised by the CDW as an impeding factor for influencing change, a view supported by this respondent:

'We have tried to [challenge service discrimination] with front-line staff through training but as band 5 CDWs we do not have access to management meetings where decision are implemented. It is easier to challenge discrimination within the community groups that we work than within the services'. (31, 26)

The issue of resources and time are twinned in this example:

'For example, I am now approached on a regular basis by statutory cohesion groups and service providers to attend meeting and events and consult on training and service provision relating to Gypsies and Travellers. Unfortunately [the] PCT have decided not to extend the CDW contract and thus this work and development will be lost'. (31, 27)

4.2 Factors that enabled workers to make a difference

Key factors that enabled practitioners to make a difference were identified in the previous section. In addition, specifically in relation to challenging stigma and discrimination, CDWs highlighted a number of key factors that had enabled them to demonstrate their impact.

- Using evidence based approaches to offering choices for change. The importance of effective needs assessments, the incorporation of service user views and a good understanding of local inequality was essential to securing support from Trusts and other organisations.
- Being passionate about equality. As one respondent said: ‘I...think being passionate and open about what I do has been helpful. I have also met many excellent professionals who do care about equality and also many highly intelligent and outstanding users and carers who are all willing to travel together with patience as long as there are some tangible markers for visible change’ (31, 8).
- Using effective evaluations of the impact of the work on communities to show changes in stigma and discrimination.
- Communicating effectively with groups, finding ‘hooks’ and ‘rewards’ that are likely to draw the community in, such as the use of creative activities or the provision of food. This links to the need to be culturally sensitive in practice.

4.3 Key findings:

- CDWs tackled discrimination in two main ways: seeking to change community views on mental health issues and service provision and seeking to influence and change service provision. This work was mostly rated positively by questionnaire respondents and there was evidence across the evaluation of meaningful and effective work.
- Cultural barriers were identified as a factor that made groups ‘hard to reach’ and in some cases a CDW’s own ethnic origin was an important factor in securing access as was the use of ‘assertive’ outreach.
- Engagement with community and faith leaders was important in terms of breaking down barriers but also in educating key opinion formers around the benefits of

mental health promotion and what services were available to support community groups and individuals experiencing difficulty.

- Partnership working and visiting local community meeting places were seen as key factors to supporting the 'credibility' of the local CDW.
- Barriers and problems were identified by respondents and in the case-study areas. These included CDW roles being cut short, short-term targets and funding including resources to undertake meaningful work and the relative status of CDWs.
- A key issue throughout was the time taken to undertake this work. It was felt by respondents to be too early to judge the effectiveness of the programme and that it was important to provide a longer-term, sustainable commitment to community development work.
- Critical success factors included a thorough evidence-base for the work, a passion and commitment for equality, evaluating the impact of the work and finding creative ways to engage with community groups.

Section 5: Conclusion and Recommendations

“Community development takes time. Disadvantaged communities have to be persuaded to participate, and their natural suspicion leads them to hang back until there is something to show.”

(Glass 2005)

“Establishing a basis of equality and social justice in service provision is no easy matter. The situation is made extremely complex by virtue of the number of forms of discrimination, the subtle and intricate ways they manifest themselves and the vested power interests which act as obstacles to change...each individual has a part to play in the major change.”

(Thompson 2001: 162)

This report has documented the findings from a small scale study of the contribution of Community Development Workers (CDWs) nationally. The employment of CDWs was a key strategy to address the problems experienced by BME communities in accessing responsive mental health services. The challenges faced by practitioners in addressing inequality were evident throughout this study, not least in terms of the central issue: inequality and social injustice take time to redress, there are no quick fixes and the work of the CDWs, even where very effective, is embryonic.

CDWs have interpreted their role in different ways and their priorities have often been determined by local implementation and their own backgrounds and interests. Striking the balance between strategic changes and what might be considered traditional community development approaches has been difficult. It is clear that where positive line management systems and intelligent commissioning is in place, CDWs feel more confident about their work and more able to influence partners in being more responsive to the needs of local communities.

There was evidence throughout the evaluation of CDWs raising awareness in communities both in terms of mental health promotion and in offering information about the approaches used by, and availability of, services. The work has been extensive, ranging from high profile events through to the establishment of new community groups. CDWs have undoubtedly been strongest in raising awareness, building capacity and influencing the attitudes of service providers. There is less evidence that they have influenced strategic policy development though new services have been brought about as a result of CDWs.

At the core of the CDW role was the call to challenge stigma and discrimination. CDWs rated this work positively. Despite a number of entrenched barriers both within communities and in services, practitioners had found effective ways to challenge these. In terms of raising awareness, they were most effective and influential when they utilised existing community and faith groups and combined this with training or information signposting. This ensured the credibility of the CDW. The issue of jobs being cut short combined with short-term targets and funding has limited the full potential of this work.

There are early yet significant indications that the funding cuts have impacted negatively on the work and contribution of CDWs. This may have consequences that go beyond the loss of individual CDW posts. Most of the interviewees in this study had been engaged in setting up and supporting new groups, specifically targeted at strengthening the collective capacity of the BME communities. Without these roles in place, there is a greater chance that community groups will be unable to interface effectively with service providers.

5.1 Critical success factors

Where the CDWs have made significant contributions, there are a number of key factors that make a positive contribution to the work. We have summarised these to inform future thinking about how to best embed community development work approaches in addressing inequality.

5.1.1 Support for the role of the CDW

- The role and contribution of the CDW was at its best when **line managers in employing agencies understood the purpose, values and approaches of a CDW.** This ensured clarity of purpose within the employing organisation and enabled the worker to feel valued. In turn, this enabled the CDW to have ‘role confidence’ when working with partner agencies who may not have fully understood or valued the CDW role.
- Alongside a supportive line manager, **intelligent commissioning was essential to ensure services were focused on local priorities.** Intelligent commissioning is defined here as the active engagement of commissioners in the planning and delivery of the CDW’s work. Commissioners better understood and valued the work of CDWs where they worked alongside practitioners.
- CDWs that **used the networks available to them** felt more reassured about their work, were able to share good practice and draw on resources as well as discuss difficulties in the work.

5.1.2 Making a difference to service provision

- Where CDWs **underpinned their work with a strong evidence base,** they were more likely to convince service providers to be more responsive to the needs of the local BME communities. Examples of this included good local needs assessments and community based profiles and research.
- CDWs who **worked effectively with a range of partner organisations** were more likely to see the introduction of new support groups and services for the local BME community.
- The **training of professionals around BME issues and cultural competence** was essential in ensuring changes of attitudes amongst service providers.

5.1.3 Making a difference in communities

- CDWs who sought to **influence key community opinion formers and faith leaders** were more likely to ensure the credibility of their messages. This meant that mental health awareness and information about services could be ‘cascaded’ from the CDW

to local faith leaders through, for example, training. This in turn would ensure that faith leaders could advise their congregations appropriately.

- Using **existing networks and community groups** was also an essential factor in ensuring credibility. Building mental health awareness into the work of existing community groups and simply ‘being around’ local communities was seen as important for removing the ‘distance’ seemingly imposed by the practitioner’s role.
- Practitioners needed to find the **right language** both in terms of breaking down language barriers but also in making sure that certain terms commonly used in psychiatry were avoided if they carried different meanings or were likely to cause offence.
- CDWs needed to learn about the **existing community attitudes towards responding to mental health problems** before they could provide appropriate information or highlight the potential benefits of using NHS services.

5.2 Recommendations

Our overarching recommendation, based on albeit a limited evaluation, is that the work of the CDWs should be continued, developed and supported by local commissioners.

We strongly endorse the community development approach in helping to challenge stigma and discrimination both in communities and in service provision. Whilst quantitative impact measures are hard to determine so early into the work of the CDWs, there is evidence of increased community engagement, better service responsiveness and changes in attitudes both amongst professionals and community members. These have the potential to improve mental wellbeing outcomes in local areas and provide more effective services for BME communities.

We acknowledge the changing financial climate within which CDWs operate but we are also mindful of moves towards strengthening community participation and engagement, evident in the current government’s ‘Big Society’ agenda. These ambitions will need to be supported by dedicated community development workers who can provide the ‘bridge’ between

services and communities, strengthen community capacity and enable groups to articulate their concerns.

It is our assessment that failure to continue this work may result in the undermining of community groups and a weakening in the responsiveness of mental health services to local BME populations.

In order to develop the work, we make a number of specific recommendations:

- Whilst it is acknowledged that local variation in the role has enabled it to flourish, **there is a need to provide greater consistency in terms of role definition and expectations.** We would therefore encourage alignment between the job descriptions of CDWs with the expectations of the National Occupational Standards for Community Development Work.
- Commissioners and employing agencies will need to ensure that **adequate resources over and above the CDW salary are made available to develop projects.**
- Employing organisations will need to **commit themselves to supporting the professional development of CDWS** through an appropriate programme of training and access to other forms of continuous professional development.
- The current **national and regional support networks** should be maintained and strengthened. In the absence of a national body, these networks will provide an important collective voice for CDWs and an arena in which to share good practice.

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