



# Great Expectations:

The Value of the Community Development Worker Role in Mental Health

Final Report: 8th January 2010



## EXECUTIVE SUMMARY

### 1.0 INTRODUCTION

This report has been commissioned by Yorkshire and Humber Improvement Partnership (YHIP). The aim of the research is to provide a review of the effectiveness of the 'Community Development Worker' (CDW) role which is being used to improve the experiences of black and minority ethnic (BME) people in mental health service provision. A specific focus of the research was to understand:

- How CDWs demonstrate their added value and impact;
- The 'conditions' that can help to make the CDW role successful;
- How to commission CDW activities more effectively in the future.

Part of the focus for the work is the future of commissioning arrangements and the opportunity for CDWs to have some influence over commissioning specifications going forward.

### 2.0 APPROACH TO RESEARCH

The research that informed the report involved a short and contained programme of work. This included:

- Review of secondary research on the CDW role and national policy drivers.
- Connecting with 28 CDWs out of a total of 50 based in the Yorkshire and Humber Region to elicit their views using standardised questionnaires, an online survey, face-to-face and telephone interviews and focus groups.
- Interviews with potential commissioners.
- Interviews with service users.
- Interviews with third sector organisations and statutory bodies that employ CDWs.
- Opportunities for CDWs to feedback on the draft report, including written submissions and a focus group of 13 CDWs in December 09.

Results from this research were collated and analysed to respond to the research aims listed above. It should be noted that although efforts were made to talk to a broad cross-section of CDWs and other relevant stakeholders.

### 3.0 KEY FINDINGS AND RECOMMENDATIONS

The key findings of the research were as follows:

#### a) *Background/ Skills of CDWs*

Most but not all CDWs had some prior experience mainly in areas of 'care' – e.g. social work, education, youth work). A sizeable minority of the sample interviewed – just over one quarter – did not.

Some CDWs saw an ability to speak specific community languages – and in some cases personal membership of an ethnic minority group – as essential attributes of working with and being accepted by particular communities. There was not unanimous agreement on this, however. CDWs at the focus group debated this issue extensively. It was agreed that the role required effective communication and empathy but some CDWs felt strongly that this could be accomplished without full knowledge of a language other than English.

#### b) *Support, supervision and induction into the role*

Some CDWs expressed concern about their line management arrangements and their relative isolation within the system from other professionals with whom they are expected to work (this was especially the case with CDWs in rural areas).

- In the main, the CDWs placed within statutory providers seemed to have access to more regularised support structures, supervision, and staff development opportunities but again this was not universally the case and employment differences between statutory and voluntary sector hosting of the role were not absolutely clear cut. Some CDWs also expressed the view that statutory provision is 'hampered' by a multitude of internal changes, with a knock-on effect on the consistency of CDW support arrangements.
- In many cases there appeared to be a lack of 'organisational memory'. Why were CDWs employed in the first place? How should they be connected into wider mental health provision and what should they be doing?
- Where third sector organisations are the host employer, there appears to be the potential for quite wide interpretation of how the CDW role is utilised, with CDWs sometimes undertaking activities in line with their employers' own functions and/or priorities. In other instances, the role is interpreted based on CDWs' personal experience and sector understanding. An absence of clear direction or clearly and consistently communicated guidance leaves some CDWs having to determine their own priorities and targets.
- Overall there appeared to be a lack of systematic development opportunities and a lack of transparency about the appointment process – in particular

appointment to more senior CDW Lead roles as opposed to standard CDW roles.

There were, however, also examples of good practice. One third sector organisation, for instance, had collaborated with a local university to interpret the CDW interim guidance into a mandatory induction and development programme for CDWs. Leeds also has a rich archive of CDW activities and initiatives that are helpful in illustrating both good practice and the variety of interpretations placed on the role. This research examined over forty case studies and these illustrate:

- Community-based and statutory sector partnership working.
- Community-based initiatives intended to raise mental health awareness and access issues – most frequently with specific groups/communities.
- Constructive use of existing networks, events and programmes to facilitate community outreach.
- Culturally-sensitive activities and/or approaches.<sup>1</sup>

**c) *Expectations about the role – what CDWs do***

National guidance exists regarding what the CDW job should involve, and recruitment and subsequent induction and support. Broadly speaking the role encompasses:

- Working to the Delivering Race Equality strategy;
- Supporting service reform;
- Engaging existing and potential service users; and
- Better information, guidance and support for communities, including the provision of language services, and partnership working.

A shared expectation about the role amongst the CDWs we interviewed was their part in undertaking outreach, sharing knowledge of mental health systems with people, empowerment, community development and capacity building. Referrals to secondary and tertiary care, some provided within the third sector, played an important role here. However, we also found CDWs' day-to-day activities varied quite considerably. For example, some found themselves in fairly influential positions, where they could potentially inform and improve services, while others had no access to such decision-making forums.

Not surprisingly, there were different views amongst CDWs about what 'community development' itself means. The purpose of the community development function was not entirely clear amongst respondents. Many found community development difficult to define, and recognised that there was an overlap with community engagement and third sector capacity building activities, and in some cases these activities had become almost synonymous.

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<sup>1</sup> See <http://drop.io/cdwcasestudies>

**d) Challenges faced by CDWs**

Here, three key issues emerged very clearly:

- Many CDWs appeared to be overwhelmed by employers' expectations for the role. Some also said that additional obstacles to the effectiveness of the role arose from a lack of commitment to (or understanding of) Delivering Race Equality on the part of their employer-organisation, and from inappropriate systems and structures.
- Of the CDWs interviewed 25 said they found it hard to understand whether they were making an impact because there is little requirement for them to measure their performance consistently. Only two of the CDWs interviewed could confidently identify measurable performance indicators or targets that they felt they had been set, or were systematically working towards.
- Some CDWs found primary care professionals in different parts of the healthcare system resisted engaging with them. In other instances the work of CDWs was being replicated in other parts of the healthcare system without their knowledge. CDWs felt this presented a missed opportunity to join up work across the system.

**e) Equality Practice**

There was no clear definition of what 'cultural capability' means, and practice was widely varying across the CDW constituency. As a consequence, CDWs often found it challenging to share learning and agree on 'best' practice. There is a personal cost to the role, with many CDWs feeling exhausted by their efforts, both within and outside of the community.

**f) Service User / Community Feedback**

From our limited interaction with the wider community at large, there was little acknowledgement and understanding of CDWs' roles. This is probably because communities are unable to distinguish between the various roles that support mental health.

However, some service users also challenge the legitimacy of CDWs, believing that service users themselves are better placed to identify and feed back views of the community on mental health care.

**g) Commissioner Feedback**

Commissioners are becoming more aware of the underperformance of some CDWs. A lack of clarity in relation to the appointment process and skill-set has meant that the abilities and skills of CDWs vary widely (as does quality of delivery).

Secondly, the capacity of organisations that employ CDWs also varies widely, and this has an impact on their ability to direct and support the role effectively.

Our findings were broadly in line with other national research and some of these issues are faced by CDWs in other regions.

There is a further less frequently articulated reason for under-performance of the CDW role, however, and this is a lack of clarity, purpose and consistency in how the role is commissioned. As long ago as 2006 the Department of Health noted (in *Community Development Workers for Black and Minority Ethnic Communities: Final Handbook*) that: "it is clear that some localities have not fully grasped (yet) that the CDW has a strategic role rather than being a support or link worker whose focus is concentrated on the individual service user".<sup>2</sup> Such wide divergences in interpretation are still apparent. The handbook also notes that those occupying CDW posts have something of a 'blank canvas' and that there are no prescribed 'template' solutions for responding to particular issues. Consequently, the ability to self-manage and to work on one's own initiative (the handbook says) are critical. This is true.

But it is also arguable that in order to achieve this strategic purpose, the CDW role should have been commissioned with far greater strategic intention from the outset. Only this would have given it the capacity to make a real contribution to service transformation.

#### **4.0 ANALYSIS AND RECOMMENDATIONS**

This research identified a broad range of issues that will need to be considered if the CDW role is to become more effective and is to be commissioned well. The report offers a number of 'high-level' recommendations that will need to be discussed further to ensure they fit with local expectations and delivery arrangements:

##### **4.1 Improving the conditions the role operates in**

There is a need for:

- Structured and regular support for those undertaking the CDW role.
- Clear development opportunities in line with the role expectations and 'professionalisation' of the role based on a clear and consistent skill-set and clearer induction and orientation).
- CDWs to have systematic access to service reform and decision-making structures within trusts where they can share input from service users. CDWs

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<sup>2</sup> Mental Health Policy Implementation Guide: Community Development Workers for Black and Minority Ethnic Communities – Final Handbook, p.5., Dept of Health (Nov 2006).

often lack the power, influence and skills necessary to play the role of 'change agents'.

In addition:

- There also need to be clear expectations about the responsibilities of the CDW role and the type of information that colleagues can expect in return. This can be linked to processes for performance management and can support the commissioning function (identifying best practice and gaps in CDW provision that may need to be filled).
- The health sector needs to be clearer about its responsibility for service redesign and reform. Where there are mainstream roles that have this remit, these too should have performance measures in relation to health inequality and BME communities. Furthermore, if CDWs are to have a role in informing service design, then the pathway by which they should achieve this should be mapped out internally.
- The third sector also needs to take responsibility for the support and development of CDWs and it should offer clear professional pathways for the supervision and support of the role.

#### **4.2 More clarity about the skills required for the role**

Expectations of the CDW role vary significantly, as do interpretations of the required skills-base, and as a consequence CDWs often face challenges in responding to these expectations. There therefore needs to be a realistic reassessment of:

- Whether there are too many differing skills-sets within the job description for this role and the impact this has on the likelihood of finding individuals who have those skills. There also needs to be a clear match between skill-set and remuneration.
- Whether the wide-ranging job description enables the CDW role and individual skills to be clearly matched to community needs and community expectations.

In addition, the skill of community development isn't 'assessed' in the recruitment process, and it is assumed that community knowledge is an inherent skill gained by virtue of community membership. This can devalue the role.

#### **4.3 Better approaches to measuring CDW performance and impact**

There are a number of challenges associated with current approaches to measurement. For example, CDWs often lack a clear work programme and are not required to gain feedback on what they do – so there can be a mismatch with 'one

size fits all' indicators of performance. Similarly there are differing views about what effective equality practice looks like. Therefore:

- Better measurements are needed to assess the impact of CDWs. We would caution against setting in place 'artificial measurements' which will seek only to measure the *activity* of CDWs (e.g. number of people supported) rather than the impact that they make overall. The full report contains detailed suggestions about how this could be achieved using existing data.
- There is also a need to re-examine assumptions about 'effective practice' when working with and supporting BME communities. Commissioners should carefully consider available evidence about whether current approaches to equality interventions in mental health are fit for purpose. BME people have widely different needs within and between communities. Sometimes being able to speak a community language is not enough. Rather, assessing whether CDWs are able to respond to the fullest range of community needs will require a broad and forward thinking view of effective equality practice.

#### **4.4 Meeting community expectations**

While the health service has a responsibility to manage community expectations, this should not be accomplished at the expense of delivering equality of outcomes – even if communities appear satisfied by the services they receive. However, in utilising the CDW role it is also important to acknowledge that:

- 'Outreach roles' such as those occupied by CDWs are not a short cut for or a replacement of interacting with BME communities.
- BME communities have expectations about services and how interventions will be delivered. This often means that communities 'expect' to be treated by people from 'their own community' because they are conditioned into believing that they will have a better quality of service if they do. There is little evidence to support this assumption. Arguably all staff should meet this expectation and the potential of creating a dual service should be avoided.

#### **4.5 The cost of care**

Reviewing the cost of care for people from different ethnicities in relation to equality of outcome would be likely to offer some real levers for mainstream change. In particular it would help to understand inefficiency in 'BME-specific' initiatives and would help to pinpoint examples of differential treatment or discrimination. The redesigning of mainstream provision needs to be cognisant of specific issues that relate to BME groups and use this information to 'design out' inequality of service provision.

The recommendations within the Y&H Healthy Ambitions strategy need to draw upon the findings in this report as a means to supporting the improvement of the mental health care pathway for BME groups.

# Full Report

## 1.0 Introduction

In April 2009 the Yorkshire and Humber Improvement Partnership (YHIP) commissioned brap to review the Community Development Worker (CDW) role as currently carried out in the Y&H region.

YHIP requested a speedy review of the effectiveness of the Community Development Worker role with the aim of improving the experiences of black and minority ethnic (BME) people in mental health service provision.

The objectives of this work were to:

- Gather information about the role of CDWs.
- Explore the ways in which the CDW role demonstrates added value and the 'conditions' that can help to make the role successful.
- Explore the impact of the CDW role on BME mental health service provision.
- Use this data-gathering exercise to make recommendations to commissioners about how they can commission more effectively within this area.

## 2.0 Background

This report has been written against a backdrop of massive change within the NHS. Healthy Ambitions, the Yorkshire and Humber's strategic response to High Quality Care for All, suggests an ambitious agenda for system and service reform. The adoption of QIPP (Quality, Innovation, Productivity and Prevention) has also been promoted as a key driver for this change and is seen as a means of reducing wide variations in the quality and outcomes of health care and experience in the Y&H region.

Projects of this nature – the strategy of employing Community Development Workers as a means of improving BME mental health care and experience – face an ongoing challenge in finding their natural home amongst the many mainstream service improvement policies and initiatives, but it is essential that they do if the Y&H region is to deliver effectively to all its population.

### ***A complex environment***

The total BME population (all minority ethnic groups) of Y&H is estimated to be around 8% of the total population. Overall, only London and the West Midlands are more ethnically diverse than Y&H. Around 20% of all people of Pakistani origin in

Britain live in the region. But BME populations across Y&H differ dramatically – from less than 3% in the East Riding of Yorkshire PCT area, to between 15%-25% in the PCT areas of Bradford & Airedale Teaching PCT and Kirklees PCT. This makes both the deployment and effectiveness of the CDW role difficult to assess, as their geographical and demographic situation can vary so considerably.

Y&H over the past twenty years has been characterised by massive structural economic change, and recent signs – such as the election of Andrew Brons, one of the first two BNP members of the European Parliament – suggest that white working class disadvantage and disaffection are now key issues with major implications for community relations, social cohesion, and the strategies that public service providers and policy-makers adopt to meet these challenges.

The size, complexity and geographical coverage of the NHS in Y&H also presents its own logistical, operational and performance difficulties. The NHS represents about 12% of the economy in Y&H and employs over 140,000 people – this includes 38,000 NHS nurses, 9,000 GPs, consultants and dentists and 2,339 paramedics and qualified ambulance staff. Y&H has 14 Primary Care Trusts (PCTs), 15 acute trusts, four mental health trusts, two care trusts and one ambulance service. There are more than 800 GP practices, with distribution varying greatly across the region. In addition, there are 30 independent providers of acute medical and surgical services, 16 independent mental health providers and nearly 1,700 care homes.

### 3.0 The Policy Context

The Healthy Ambitions<sup>3</sup> strategy is endorsed by the health leadership of Yorkshire and Humber as route map for delivering high quality services. The strategy identified that in relation to mental health there was

‘...considerable variation in services provided in localities and the speed in which services have been modernised. It also found some pathways complex and difficult to navigate for professionals, users and carers.’ (Healthy Ambitions p.107.)

The integration of specialist services with mainstream provision appears to be an ongoing challenge, which is contributing to the complexity of the referral pathway. Coupled with this is acknowledged poor access to psychological therapy and talking therapy approaches, despite the evidence of their benefit.

The role of the Community Development Worker (CDW) is a direct recommendation from the *Delivering Race Equality in Mental Health Strategy 2005 (DRE)*<sup>4</sup>. The DRE is in its final year of a five-year strategy for tackling discrimination in the NHS and

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<sup>3</sup> Healthy Ambitions (2008) Y& H

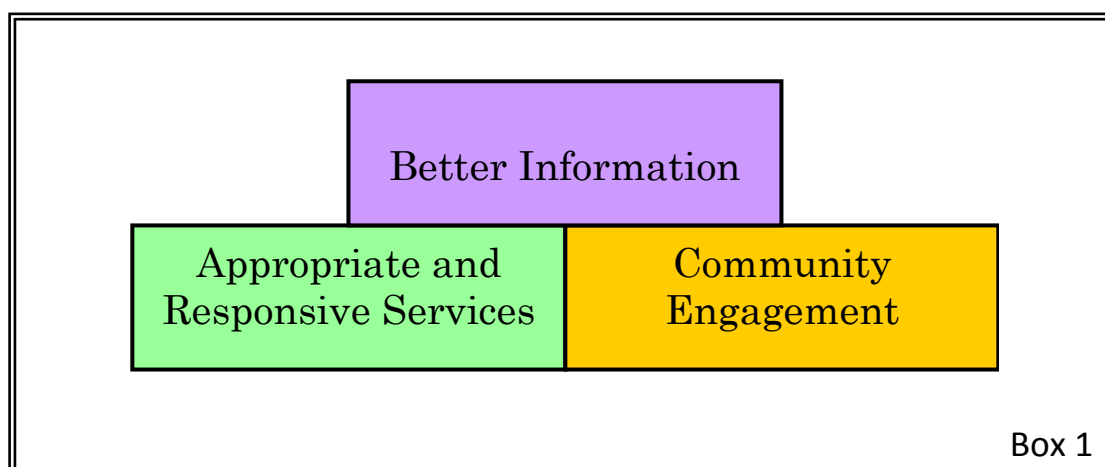
<sup>4</sup> DOH, *Delivering Race Equality in Mental Health: An action plan for reform inside and outside services*, 2005

local mental health services. Since the origins of this strategy, local mental health trusts have varied in their response to employing CDWs as a means to supporting service development. An essential part of the CDW role is the navigation through a complex mental health system. This strategy has resulted in a range of employment options, where CDWs have been directly employed by Trusts and by voluntary and community organisations (see 4.1 for more information).

The emergence of a commissioning climate for the NHS and other public services has presented the opportunity to reflect on the CDW role and impact, and in particular to consider available evidence upon which future commissioning parameters could be based.

This research has directly engaged with CDWs in the Y&H region, in addition to drawing upon national secondary research, as a means of painting a picture of the CDW role and illuminating what is working well and where there is room for improvement. In fulfilling the brief we were also careful to suggest some guiding principles that could be used to support future commissioning arrangements. Whilst we recognise that this report is not fully comprehensive, we believe it does offer a number of areas for reflection, with clear, practical recommendations which could, if adopted, enhance the quality of BME mental health service provision as well as the careers of those whose responsibility it is to work towards this aim.

## The Policy Context for BME Mental Health Service Reform



We have already mentioned the DRE – the primary driver for mental health reform, heralded for its explicit outline for improving the experiences of BME service users.

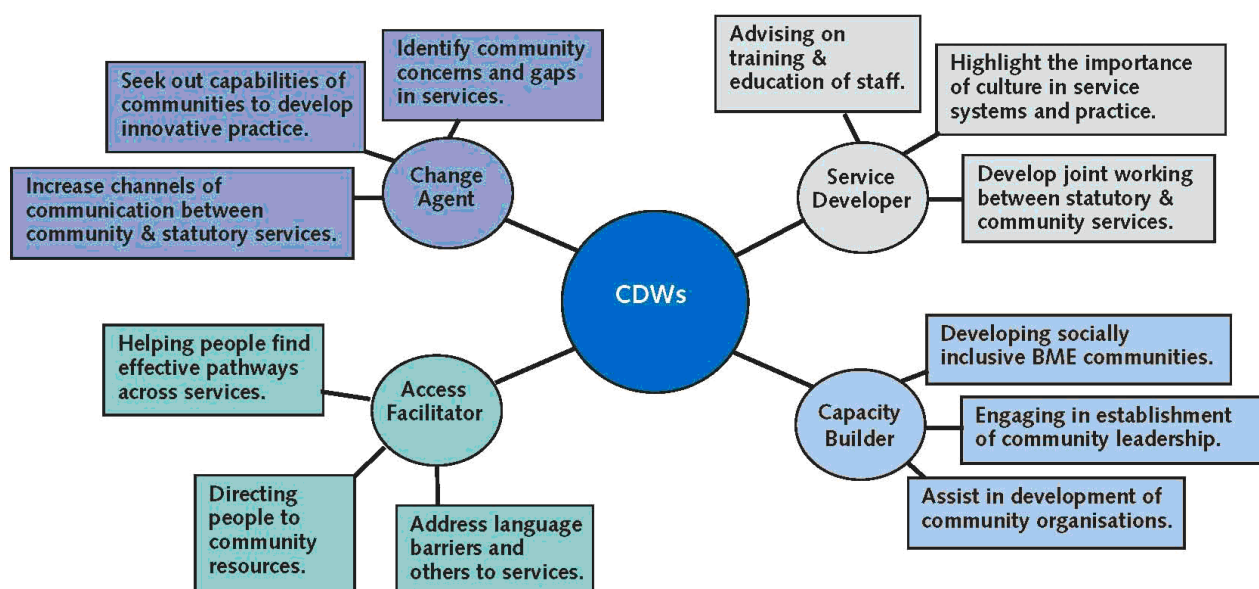
The DRE building blocks – creating appropriate and responsive service provision; community engagement; and providing better information – are intended to combine as a means to create a platform for service reform. The CDW role could be described as a means to support effective community engagement, which drives service expectations and improves provision. The role responds to and recognises both the under-utilisation of appropriate services by potential BME mental health service users and the over-representation of BME mental health clients within some types of mental health services.

The experiences of BME mental health service users within the system are widely different from their white ethnic counterparts. Many of the problems experienced by BME patients happen once they interact with the service – i.e. the treatment experienced by BME service users, once on the care pathway. The purpose and role of CDWs was intended to work from the 'outside in', connecting BME services users with the mental health care pathway. *Guidance for the CDW Role (Dec 2004)*<sup>5</sup> described four main areas of intervention where CDWs could act variously as:

- **Change Agents** – identifying gaps, developing and modelling innovative practice.
- **Service Developer** – promoting joint working, education and training for all.

<sup>5</sup> DOH, *Community Development Workers for BME communities, Mental Health Implementation Guide*, Dec 2004.

- **Capacity Builder** – in BME communities, working with organisations that could deliver mental health services in the future.
- **Access Facilitator** - to services, community resources and overcoming language and cultural barriers. The diagram below, taken from this publication, describes this role in more detail:



'*New Horizons: Towards a shared vision for mental health*' (July 2009),<sup>6</sup> sets out a 2020 vision for the nation's mental health. The strategy recognises both the importance of mental health for the whole population, and improving the quality and accessibility of services for people with poor mental health. The strategy also recognises the socio-economic factors that can contribute towards ill-health and impact on recovery. It describes local initiatives, such as the establishment of Community Development Workers, as a measure that can be employed to promote better mental and physical health in BME communities. The case study cited in *New Horizons* describes the experience of a CDW in South Tyneside:

'My biggest challenge is raising awareness of mental health issues among communities who don't even have a term for 'mental health'... So I do a lot of work to engage these people. Community Events are always a good vehicle for raising awareness.'<sup>7</sup>

*High Quality Care for All* (DoH 2009) moves the agenda on from engagement and service reform, to individual choice through personalisation. Yorkshire and Humber

<sup>6</sup> DOH, *New Horizons' Towards a shared vision for mental health*, July 2009,

<sup>7</sup> *Ibid.*, p.52

has described its approach to delivering on this agenda which includes 7 levers for action:

- Leadership and strategic direction
- World class commissioning
- Assurance and performance
- Metric development
- Information management & technology
- Education
- Leadership development and innovation.

The vision for quality improvement is anchored within the commissioning role and focuses upon the need for effective commissioning arrangements to draw upon a range of data, including that of patients' views and experience, to ensure that services provide better quality and better value for money. Clinical and board leadership is seen as key to driving through these intended changes, and the strategy emphasises the role of clinicians as a means to re-engage staff and to drive forward innovation and change. The actions of leaders will set the values and behaviours which will drive cultural change. The system must become more receptive to listening, interpreting and acting on information, however, if it is to meet the challenging standards it has set for itself. Measurement is central to understanding service improvement – and the Y& H strategy refers in particular to innovation metrics that will be used to understand and gauge impact in improving quality and productivity.

The role of commissioning as a tool to improve the quality of provision requires the use of evidence in order to understand *what* to commission, *who* to commission and what *outcomes* to expect. However, when discussing BME mental health provision, there is a lack of clarity and evidence about which interventions really work in addressing the negative outcomes experienced by BME communities. Understanding how to make an impact on BME health inequality may mean moving away from the norm and daring to commission new activity which does not fit into *accepted* models of supporting BME communities. In this context, the continued focus on community engagement and consultation may need to be revisited, with more emphasis being placed upon the system demonstrating that it can *act* on the evidence it receives (through consultation and engagement activities) rather than merely listen.

The Darzi Next Stage Review<sup>8</sup> is all about a vision for achieving change within the NHS. The re-shaping of services is seen as a job for leadership, and in particular clinical leadership and the engagement of staff, partners and the public. Commissioning therefore, is not an isolated lever and must be seen within the context of system change and the quality and productivity challenge. The first principle of the Next Stage Review – that of subsidiarity – is critical to understanding

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<sup>8</sup> Implementing the Next Stage Review visions: the quality and productivity challenge – 10<sup>th</sup> August 2009  
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the action that needs to be taken to move the BME mental health agenda forward. Understanding the needs of existing and future customers, and how commissioning can be organised to deliver enhanced quality of outcome, will require innovation.

## 4.0 Methodology

A number of approaches were chosen as a means to collect appropriate data to inform this work:

- Review of secondary research on the CDW role and national policy drivers.
- Connecting with 28 CDWs out of a total of 50 based in the Yorkshire and Humber Region to elicit their views using standardised questionnaires, an online survey, face-to-face and telephone interviews and focus groups.
- Interviews with stakeholders (potential commissioners).
- Interviews with Service users.
- Interviews with third sector organisations and statutory bodies.
- Opportunities for CDWs to comment on the draft report, in written form and in a focus group.

CDWs were informed that the information collated would be anonymised and in some cases brap has been unable to draw upon data, where it would have been obviously attributed to particular areas, organisations or individuals.

### 4.1 CDW Data Collection

CDWs were asked a range of questions (see Appendix 1) covering: their professional skill set; what they spent their time doing in the role; where they felt most effective; their views on community development; their relationships with other staff (Clinician's etc); the challenges of their role; and how well the role was understood within the service overall.

Overall there are approximately 50 CDWs in the Yorkshire and Humber region. We attempted to make contact with all of them. In total we managed to contact 28 CDWs using the above methods. Almost three-quarters of our sample of CDWs were employed by voluntary sector organisations of various kinds. The sample also included CDW Leads with considerable differences in both the number of CDWs they had responsibility for and the geographical area covered.

## 4.2 Methodology Limitations

There were some challenges in relation to accessing CDWs within the initial timeframe, although extending the timeframe did not lead to greater number of CDWs becoming involved in this work. Systematic information, (collected for example on employment status, time in employment, training received etc) would have made it possible to produce a more detailed comparison of the employment experiences of CDWs. As it is, such detailed comparison has not been possible – partly because of lack of appropriate information, and partly because we offered CDW respondents the option of anonymising their replies: those that opted for anonymity – and indeed some who didn't – did not provide employer details.

Of the CDWs across Y&H that we were able to identify, our records suggest that just under half are employed by third sector organisations, with these ranging from mental health-specific organisations, to relatively small faith-based organisations, to community groups and other kinds of voluntary sector networks.

## 5.0 Research Findings

### 5.1 Background and Skills

***CDWs were asked about their professional backgrounds, and 'prompted' through interviews to explore the match between their previous skill sets and their current role. We also asked CDWs about their induction into their role and their professional development.***

The CDWs interviewed came from a wide range of mainly 'care' type backgrounds – youth work, sure start, social work, education, drugs and mental health.

The majority of our sample of CDWs had some type of professional background, but there were 8 – just over one-quarter of the sample – who said they did not consider themselves to have any professional background. Questionnaire responses emphasised skills in working with communities, including community languages, as amongst core competencies for the CDW role. While the majority of respondents considered community languages a pre-requisite for the role, none of the CDWs interviewed had any professional interpretational qualifications. From the CDWs' point of view, knowing and being able to speak 'the language' and coming from a particular ethnic group were the essential attributes of working with and being accepted by particular communities.

The questionnaire prompts which asked specifically about CDW induction into their roles were answered fairly positively. However through both interviews and the focus groups CDWs expressed some concern about their line-management arrangements and their relative isolation within the system (especially those in rural areas).

They commented, for instance, on a lack of training, with this emerging as a particular issue for CDWs who hadn't worked in the area of mental health before and had received no specific induction on what to expect.

There was also a marked difference between third sector employment arrangements and those CDWs employed within Trusts: the latter had at least received the statutory induction.

The role requires a great deal of independent working, and whilst some CDWs found this idea liberating, others were unsure, at least at first, of how to proceed. Overall, there appears to have been a lack of systematic development opportunities for the role and a lack of transparency about the appointment process which differentiated between senior CDW Lead roles and the standard CDW role.

## 5.2 Role expectations

***CDWs were asked to share their expectations about the purpose of the role, and what the role was expected to achieve.***

The Mental Health Policy Implementation Guide, *Community Development Workers for Black & Minority Ethnic Communities* (Nov 2006), offers guidance on the induction and development of CDW roles, including the key aspects of the job, logistics behind recruitment and advice as to the ongoing support and development needs in the role. Broadly speaking the role encompasses: working to the DRE strategy; supporting service reform; engaging existing and potential service users; and better information, guidance and support for communities, including the provision of language services, and partnership working.

In practice, we found that:

- CDWs' day-to-day activities vary quite considerably. Some found themselves in fairly influential positions, where they could potentially inform and improve services. Others had no access to decision-making forums. In relation to role requirements, CDWs considered accessing these potential positions of power as being key to fulfilling community expectations and achieving service reform. The standard job description clearly states that this is part of their responsibilities (Appendix 2).
- The shared expectation amongst all CDWs interviewed was the ability to undertake outreach, and this was a key indicator of their effectiveness. This encompassed a variety of activities, from community development, capacity building work with third sector organisations and providing information to service users.
- Some CDWs used their language skills to support community members to access service provision, and increase their understanding of mental health.

### 5.3 Supervision and Support

***CDWs were asked about the expected performance within the role, and the support provided by line managers.***

*'I am employed by an organisation that does not understand [the] Delivering Race Equality agenda or the role of CDWs. I am not convinced that they wanted the post in the first instance. CDWs are tick boxes for the PCT.'*

– CDW response to the research questionnaire.

The comment above illustrates the wide range of organisational attitudes which exist towards the CDW role, and hence the effectiveness with which the role is supported, managed and utilised. Amongst respondents to our research we found that:

- On the whole, CDWs were disappointed with the support received from their line managers and in some cases respondents were unclear about who their managers were. Supervision varied from a fairly regular interaction, to some who had never seen their line manager.
- In the main, the CDWs who were placed within statutory provision seemed to have access to more regularised support structures, but amongst these there was also the view that statutory provision is 'hampered' by a multitude of internal changes, with a knock-on effect on the consistency of CDW support arrangements. In many cases there appeared to be a lack of 'organisational memory'. Why were CDWs employed in the first place? How should they be connected into wider mental health provision and what should they be doing?
- In the cases where third sector organisations were commissioned to employ CDWs, there appeared to be a lack of consistency in relation to how the role should be utilised. In these instances CDWs often undertook activities that were in line with their employers' functions and/or priorities, leading to significant differences in how the CDW role is interpreted.
- In the absence of any clear direction, some CDWs were left in the position where they determined their own priorities and targets. For some CDWs placed within statutory agencies, it was easier to align the expectations of the role to wider race equality agendas. For example, as one respondent put it: "...attending the [name of meeting], means that I contribute to increasing BME referrals to the occupational therapists."

#### **5.4 Other Support Avenues for CDWs**

CDWs also mentioned the role of CDW networks as a vehicle for offering support and sharing good practice. This became especially meaningful in areas where CDWs had little line management support or engagement with the wider service.

In terms of good practice, one third sector organisation had collaborated with a local university to interpret the CDW interim guidance into a mandatory induction and development programme for CDWs.

#### **5.5 Engaging with the System**

***CDWs were asked to describe the most difficult aspects of their role and also where they felt they were most effective?***

Many CDWs appeared to be overwhelmed by expectations for the role. The challenge, for example, of undertaking system reform is described in the words of one CDW here:

*'I feel like I'm the only person who cares about this agenda...the most difficult aspect of my job is a lack of commitment in the structures and understanding of DRE...'*

When specifically asked about performance indicators within the role, few of the CDWs in the sample could confidently identify any measurable targets that they felt they had been set, or were systematically working towards.

#### **5.6 Engaging with Clinical Staff**

Some CDWs in our sample said that some professionals on the wards were resistant to engaging with them, and in some cases even gaining access to wards had proven problematical. Sometimes those that did manage to access wards found to their surprise that they were not alone – that their remit was already being undertaken by others, for example, Service User Ambassadors roles or EPIC workers.

Although primary care engagement has been viewed as a means to enhance the quality of mental health care, CDWs found it almost impossible to access GPs.

#### **5.7 Equality Practice**

There was no clear definition of what 'cultural capability' means, and practice was widely varying across the CDW constituency. Cultural capability was seen by some as culturally or ethnically defined, and there was no clear agreement amongst CDWs about whether post-holders should 'match' the communities they were intended to work with. This reflects much wider uncertainties and disagreements in the debate around cultural capability.

There was one example, in Leeds, where a CDW working with the Chinese community who neither shares the ethnicity or cultural background of the people being served. Yet by all measures, this post holder's engagement with services users, the community and families has met with a lot of success. Service users far from being put off have reported that they felt more confident about being listened to, without ethnically-based assumptions, and about having confidentiality honoured.

## 5.8 Working in the Community

Most CDWs in our sample stated that 'working in the community' was for them the most rewarding aspect of their role. Here they were able to share their knowledge of mental health systems, empower people to take responsibility for their mental health and have opportunities to enhance community benefit. Some had managed to influence services to undertake community outreach.

## 5.9 What does 'Community Development' Mean?

Nonetheless, it was evident from discussions amongst our respondents that the precise purpose of the community development function remains unclear. Many found community development difficult to define, and recognised that there was an overlap with community engagement activities, and in some cases the two terms had become almost synonymous.

CDWs described community development variously as:

*'...helping communities to identify their unique skills and knowledge base and then supporting them to identify their needs and how to achieve them'*

*'Empowering individuals to find a common interest and as a means to bring people together'*

*'...it is about supporting services to explore their ways of delivering, to embrace good practice and to recognise where changes are required'*

*'to enable positive community growth'*

CDW responses to the research questionnaire

Some CDWs were also involved in supporting third sector organisations to become engaged in mental health provision and saw themselves as supporting these organisations to secure commissions to deliver services.

### **5.10 Interaction with Service Users/Carers**

Some CDWs cited examples of where they had been able to 'catch service users at an earlier stage of their illness' and in doing so prevent them from becoming so unwell that they had to be admitted into statutory care.

CDWs also actively referred clients to third sector organisations that could support patient care. There were other examples of CDWs who had helped clients to understand their condition and keep themselves stable and well, thus avoiding relapse situations.

### **5.11 Service User/Community Feedback**

From our limited interaction with the wider community at large, there was little acknowledgement (or understanding) of the CDWs' role. We suspect that this is because communities are not able to distinguish between the various roles that support mental health.

Responses did, however, identify some slight tension between CDWs and service-users. In some instances service-users, by virtue of their experiences in the mental health system, consider themselves to have a legitimacy which CDWs don't possess. This has created 'competition' between service-users and CDWs. The recent appointment of service-users into some CDW roles would suggest that there is an overlap between 'activists' and 'professionals', and that at least some service-users have an interest in moving into paid CDW roles.

### **5.12 Commissioner Feedback**

Commissioners are becoming more aware of what they view to be the 'under performance' of some CDWs. There are two key reasons why under performance appears to be an issue:

- Firstly, commissioners have realised that the skill-sets of individuals appointed into the CDW role can have a real impact on their ability to fulfil the expectations of the role. This is because there is such a broad skill-set for the role, and the abilities and skills of CDWs consequently vary widely.
- Secondly, the capacity of organisations that employ CDWs also varies widely, and this has an impact on their ability to direct and support the role effectively.

There is a further less frequently articulated reason for under-performance of the CDW role, however, and this is a lack of clarity, purpose and consistency in how the role is commissioned. As long ago as 2006 the Department of Health noted (in *Community Development Workers for Black and Minority Ethnic Communities: Final Handbook*) that: "it is clear that some localities have not fully grasped (yet) that the CDW has a strategic role rather than being a support or link worker whose focus is

concentrated on the individual service user".<sup>9</sup> Such wide divergences in interpretation are still apparent. The handbook also notes that those occupying CDW posts have something of a 'blank canvas' and that there are no prescribed 'template' solutions for responding to particular issues. Consequently, the ability to self-manage and to work on one's own initiative (the handbook says) are critical. This is true.

But it is also arguable that in order to achieve this strategic purpose, the CDW role should have been commissioned with far greater strategic intention from the outset. Only this would have given it the capacity to make a real contribution to service transformation.

### 5.13 Related Research

The primary research findings from the Yorkshire and Humber region are very much in line with the findings of a national research report commissioned by the National Institute for Mental Health in England by Dr Reg Walker and Professor Gary Craig, Elliott Walker Consultancy (March 2009).<sup>10</sup>

Walker and Craig's evaluative report found that:

- The initial **recruitment** of the target number of funded CDW posts for the YHIP region was a somewhat bumpy road, leading to
  - difficulty in clearly identifying or **naming post holders**
  - Pin-pointing what the **local expectations of the role** would be.

There were further difficulties highlighted:

- The **absence of a job description** or indifference to the objectives of the role in some areas.
- **Differences in pay** between those employed by third sector organisations and those employed by statutory bodies, (with salary differences that seemed to be patterned according to ethnicity).

In addition, Walker and Craig found, in areas with high expectations for the CDW role:

- **Training and development were neglected**, resulting in varied experiences and backgrounds of those recruited.
- Levels of **activity between CDWs differed**, with some appearing to do very little that could be described as meaningful activity (i.e. having an impact on

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<sup>9</sup> Mental Health Policy Implementation Guide: Community Development Workers for Black and Minority Ethnic Communities – Final Handbook, p.5., Dept of Health (Nov 2006).

<sup>10</sup> Community Development Workers for BME mental health: Embedding Sustainable Change': (2009)

service users, communities or service delivery), while at the other end of the scale there were CDWs who were clearly over-stretched, over-worked and unappreciated by mainstream services.

Finally, Walker and Craig also found evidence of widespread concern relating to **poor line management** and supervision.

## 6.0 Analysis

This research has identified a broad range of issues that will need to be considered if the CDW role is to become more effective and is to be commissioned well. Firstly there is a need to improve the conditions in which the role currently operates (e.g. support available to CDWs). Secondly, there is a need to be much clearer about the function and skills of CDWs and to measure their performance more effectively. This section discusses some of these issues in more detail.

### 6.1 Improving the Conditions the Role Operates In

#### ***Structured and regular support for those undertaking the role***

The health system is not getting best value out of staff it employs if they are not well inducted, supported and there are few development opportunities in line with the role.

The peripatetic nature of the CDW role means that it is crucial that there is good line management in place. A role that has a high level of autonomy requires clear expectations of performance, and line managers who understand the purpose of the role and have a clear vision for how it is to be achieved.

The activities undertaken by CDWs (outreach, community development etc) mean very little unless they fit into the overall strategy of the Trust, and are seen as valuable.

#### ***Clear development opportunities in line with the role expectations***

Induction and orientation into the role is crucial in supporting any individual to understand how to perform the job effectively.

Walker and Craig identified that job security, clear pay levels, and career progression are very live issues for CDWs. Our questionnaire and interviews also revealed that some CDWs feel that the professionalisation of the role is desperately necessary, and that it should be given a status within the care profession.

#### ***Access to service reform/decision making structures within trusts where CDWs can share input from service users***

If there is an expectation that CDWs contribute to service reform, then the services need to provide clear avenues for this to take place.

Many CDWs expected that the pathways to service reform would be clearly articulated and that their input would be a welcome addition in this regard. Many were surprised when the system resisted their participation.

Furthermore, some CDWs have not yet been able to develop the strategic skills necessary to be able to 'court' individuals whose support they needed.

## 6.2 Whose Responsibility is it to 'fix' the System?

It is a tall order to expect BME service users themselves to take primary responsibility for service reform. Similarly, given the positions that many CDWs occupy, they face challenges playing the role of 'change agents' as they lack power, influence and skills necessary to improve the work of clinical professions.

We asked CDWs "what are the most difficult aspects of your job?" They said the following:

*"sustaining the interest of statutory mental health services  
and sometimes maintaining contact"*

*"PCT structures and the understanding of the CDW role"*

*"meeting the right people and sitting at the right tables"*

CDW responses to the research questionnaire

## 6.3 Being Clearer about Skills Required for the Role

Expectations about the CDW role are varied and the skill-base extremely wide. Broad role categories include:

- Health promotion.
- Raising awareness of mental health in its broadest sense.
- Influencing service provision.
- Working with individuals to ensure that care needs are appropriately identified and met.
- Working with the service to help it to understand how to meet individual needs.
- Capacity building with independent providers.
- Training and facilitation.
- Organising and facilitating avenues for patient support.

Any one of these functions could easily form the main part of a specialist role on their own. However CDWs are expected to have a full skills complement covering all these roles, and this expectation is somewhat unrealistic.

The pay for CDW workers has always been a contentious point. Some employers have argued that the pay is too low to attract individuals with the required skill-set. Perhaps the issue is more complex than this. It is possible that the skill-sets are so diverse that it is challenging to find individuals who are able to perform competently across all areas.

Community development is seen as a core role requirement and skill. But there appears to be little recognition of the skills required for community development activity, partly due to the fact that CDWs are employed in the main to 'match' their communities/culture or ethnic group. The ethnicity of CDWs is often assumed to provide them with the skills they need to undertake community development activity. As a consequence, the skill of community development isn't 'assessed' in the recruitment process, and it is assumed that community knowledge is an inherent skill gained by virtue of community membership. This can create further obstacles to the optimal working of the CDW role.

In order to meet the individual needs of service users, CDWs are often employed for their language skills, yet nowhere in the person specification are CDWs expected to be trained interpreters. Similarly, it is not compulsory for CDWs to have knowledge of the mental health system, and whilst one could argue that this is a skill they could learn, without a clear programme of support it has tended to be an area that CDWs learn 'on the job'.

#### **6.4 Measuring Effectiveness of the Role**

##### ***Current approaches to measurement***

Trusts have been encouraged to use qualitative data to measure year on year progress in relation to the experiences and outcomes of service users. The DRE Dashboard<sup>11</sup> encourages Trusts to measure against six headline priorities:

- Access to early intervention
- Access to crisis resolution/home treatment
- Use of assertive outreach services
- Access to psychological therapies
- Implementation of supervised community treatment (under the mental health act 2008)
- Recruitment and impact of community development workers

In the case of the recruitment and impact of CDWs, a very broad indicator – to improve, trust, confidence and outcomes for service users – has been suggested as a

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<sup>11</sup> Delivering Race Equality, *DRE Dashboard*, Sept 2008.

means to measure the role. Such indicators would be difficult to assess in any case, but doubly so in this situation where CDWs often lack a clear work programme and are not required to gain feedback on what they do.

There is an old African saying 'You can't fatten a cow by weighing it'. Equally, attributing measurements to something will not necessarily improve the overall outcome, or experience. The numbers of CDWs are considered by the DRE strategy as being a measurement of good practice in this area – but if the role or how we judge its effectiveness isn't clear, then the impact of the role on BME communities and within the service may be not be clear either. If we look at the key aspects of the role, it may be possible to use existing data, or establish baseline data, which may give an indication of additional role value.

## 6.5 Guiding Principles for Commissioners

The Acheson Report into health inequality was commissioned over 10 years ago and although time has passed there have been no significant gains in reducing the gap between life expectancy and infant mortality across all social classes. There are systemic issues which impact on the poor health of some communities, and the continued poor experiences and outcomes of some who access the mental health system. Linking the required outcome to appropriate intervention must be the core business of commissioners. The Yorkshire and Humber Ambitions for Excellence paper (Strategy for Quality, Innovation, Productivity and Prevention), calls for a 'Better for Less' strategy which would set out: the evidence for action; the approaches to be taken, and the impact that should be expected. In adhering to this example, the commissioning strategy needs to take account of the change that needs to happen both inside and outside of the patient pathway.

The table below – which is based on the responses we have received from CDWs about their key tasks and responsibilities – suggests approaches to using existing data to measure added value of the role of CDWs in key tasks. Also included in the table is an explanation of potential risks/ health warning for each approach to measurement along with the outcomes of each task.

CDW Key tasks/responsibilities	Measurements	Health warning	Outcomes
Health promotion	Baseline evidence on service take-up by ethnic group and set targets for CDW to achieve GP referrals?	Difficult to demonstrate that any promotional activity had a direct relationship to this role ( others are also involved in health promotional work )	Reduce fear of the system, promotes better understanding of services
Raising awareness of mental health in it's broadest sense	Baseline evidence on service take-up by ethnic group and set targets for CDW to achieve specific awareness-raising activities	As above	Provides potential service users with full range of 'options' within Mental Health – and contributes to early intervention target
Influencing service provision	Trace recommendations from CDW/service users into service discussion documents/impact assessments and ultimately	Difficult to understand direct impact of service user views on service improvement (number of factors will affect	Influencing targets on access, take-up and satisfaction

	<p>decisions made on how to plan services. Use patient stories to understand care pathways</p>	<p>this). However will offer a clearer 'route map' to understand how service user views are treated in 'the system' and role of CDWs in that process.</p>	
<p>Working with individuals to ensure that care needs are appropriately identified and met</p>	<p>Establish baselines on Client satisfaction by ethnicity and look for change in trends – service users coming into the system from different referral pathways</p>	<p>CDWs may need to be given 'case loads' to ensure that a) this target can be monitored and b) safeguarding requirements can be met. Client satisfaction is not a measurement that CDWs can 'control' in their own right.</p>	<p>As above</p>
<p>Working with the service to help it to understand how to meet individual needs</p>	<p>Client satisfaction Trends ( such as % of BME in IAPT), length of stay in acute wards</p>	<p>Again, CDWs cannot entirely 'own' this measurement. Access to alternative therapies may need to be benchmarked by ethnicity for all service users in order to understand the availability of this provision for all groups.</p>	<p>As above</p>
<p>Capacity building work with independent providers</p>	<p>Diversifying care pathways /community provision Patient satisfaction</p>	<p>CDWs are not budget holders and decisions on how to spend still lie with commissioners.</p>	<p>As above</p>
<p>Training and facilitation</p>	<p>Numbers in training sessions, evaluating satisfaction and post course impact</p>	<p>Usually there is a delayed reaction between training and opportunities to implement what has been learnt.</p>	<p>Can contribute to staff/user confidence</p>
<p>Organising and facilitating avenues for patient support</p>	<p>Numbers participating. Diversification of care pathways</p>	<p>The concept of 'recovery' is fluid – not always possible to measure in absolute terms the value of patient support groups.</p>	<p>People feeling better about their health and support</p>

## 7.0 Recommendations

We have highlighted that the CDW role is wide-ranging and aspirational. And in proposing the following recommendations, we would like to avoid duplicating the CDW approach. Nevertheless, these recommendations are high level, and will need practical interpretation to ensure that there is a proper fit with the expectations of the CDW role and produce tangible results for the service.

### 7.1 Improving the Conditions the Role Operates In

We would strongly advocate that the health service needs to be clearer about its responsibility for service re-design and reform. Where there are mainstream roles that have this remit, these too should have performance measures in relation to health inequality and BME communities. Furthermore, if CDWs are to have a role in informing service design, then the pathway by which they should achieve this should be mapped out internally.

Those employing CDWs – whether they are third sector organisations or public sector bodies or partnerships – need to take responsibility for the support and development of CDWs and should offer clear professional pathways for the role including:

- Structured and regular support for those undertaking the CDW role.
- Clear development opportunities in line with the role expectations (professionalisation of the role and clearer induction and orientation).
- Access to service reform and decision-making structures within the trusts where CDWs can share input from service users and where this input can be acted upon.

### 7.2 More Clarity about the Skills Required for the CDW Role

In both the Walker and Craig report (2009) and also in this report, concerns have been expressed about the expectations of the CDW role and whether these are realistic. This must be the starting point for any commissioning function. There needs to be a realistic assessment of:

- Whether there are too many differing skills-sets within the job description for this role and the impact this has on the likelihood of finding individuals who have those skills. There also needs to be a clear match between skill-set and remuneration.
- Whether the wide-ranging job description enables the CDW role and individual skills to be clearly matched to community needs and community expectations.

- How the skill of *community development* is clearly recognised within the role. Clear skills-sets need to be identified for carrying out community development activity – rather than community development being viewed as a skill gained by virtue of community membership.

We have already made the point about proper supervision and professionalisation of the role. There also need to be clear expectations about the responsibilities of the CDW role and the type of information that colleagues can expect in return. This can be linked to processes for performance management and can support the commissioning function (identifying best practice and gaps in CDW provision that may need to be filled). For example, in relation to community engagement, CDWs should:

- Have a grasp of the demographics in their respective areas;
- Be aware of the percentage of the community that might have mental health needs; and
- Be able to undertake community profiling to support commissioners to build on existing data.

This will mean that CDWs will need to have a better understanding of data collection techniques, and be better co-ordinated, supported and deployed on the ground.

### 7.3 Better Approaches to Measuring CDW Performance & Impact

There are a number of assumptions about effective practice when working with and supporting BME communities and the BME mental health services conundrum has long been considered an area of concern.

The question of how to adequately provide for people who originate from another country has been long debated, but the methods or approaches have been similar and still resemble the multi-cultural approaches advocated by *Scarman (1981)*, following his inquiry into the Brixton riots.

Again, commissioners should look at population trends, patient outcomes and experiences and assess the effectiveness of interventions. *The Equalities Review (2007)*<sup>12</sup> reviewed the impact that equalities legislation and interventions have made over the last 40 years. The trends are worrying with major gaps in the expectations and outcomes of particular groups across major indicators such as education, health and employment. The review calls for a closer examination of the interventions used to work with particular groups. There is a need to carefully consider evidence about whether current approaches to equality interventions in mental health are fit for purpose. In particular:

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<sup>12</sup> Fairness and Freedom – Equalities Review Feb 2007

- Better measurements are needed to judge impact of CDWs.
- There is a need to re-examine assumptions about 'effective practice' when working with and supporting BME communities. Commissioners should carefully consider available evidence about whether current approaches to equality interventions in mental health are fit for purpose. BME people have widely different needs within and between communities. Sometimes being able to speak a BME language is not enough. Measuring whether CDWs are able to respond to those needs will require a broad and forward thinking view of effective equality practice.

Engaging with communities (and the skills associated with undertaking this type of role) need to be valued in their own right. The types of skills associated with this role should be clearly assessed. Communities are rarely homogenous, there is a range of difference between individuals, and individuals who are second/third generation British may have totally different needs and none of the barriers (such as language) that CDWs pride themselves on overcoming.

We would caution against setting in place 'artificial measurements' which will only seek to measure the activity of CDWs (e.g. number of people supported), and not the impact that they make overall.

#### **7.4 Meeting Community Expectations**

BME communities have expectations about services and how interventions will be delivered. This often means that communities 'expect' to be treated by people from 'their own community' because they are conditioned into believing that they will have a better quality of service if they do. There is little evidence to support this, however. Although it is clear that confidence in services is raised when people are 'served' by people who understand and treat them well, we would argue that all staff should meet this expectation and that creating a dual service should be avoided.

While the health service has a responsibility to manage community expectations, this should not be accomplished at the expense of delivering equality of outcomes – even if communities appear satisfied by the services they receive. Furthermore, services should be careful that community outreach roles are not put in a position where they are 'speaking for communities' and should be wary of community members (no matter how well meaning) who make statements about groups of people. Not only does this continue to reinforce community stereotypes, it denies individual choice, and can also paralyse other professionals, who will feel as if they cannot possibly interact with a particular community as they do not know enough about 'them'.

- The health service has a responsibility to manage community expectations, but this should not be accomplished at the expense of delivering equality of

outcomes – even if communities appear satisfied by the services they receive.

- There is a need to ensure that 'outreach roles' such as those occupied by CDWs are not seen as a short cut to or a replacement for interacting with BME communities.

## **7.5 The Cost of Care**

The cost of care, especially when compared with the quality of outcome is something that commissioners will have to reflect upon as part of their role. If we were to look at just one area of care, for example admissions into acute wards, the length of stay for BME patients is in excess of the 'white' average. Not only does this have implications for the cost of this service, but also for the long-term recovery of the patient. Reviewing these issues could be a lever for mainstream change, especially if patient conditions are similar and there is evidence of differential treatment with no clear rationale.

Yorkshire and Humber's Healthy Ambitions strategy (May 2008) is built upon a comprehensive review of mental health provision in the region. Recommendations do not appear to differentiate 'groups' of people that experience the worst and best outcomes, but there are actions which are designed to improve the care pathway. These recommendations include better development of the roles of staff (specifically Primary Care MH teams), reviewing referral routes and access to appropriate interventions.

The recommendations within Y&H Healthy Ambitions need to draw upon the findings in this report as a means to supporting the improvement of the mental health care pathway for BME groups.

## 8.0 Conclusions

This research was commissioned to examine the effectiveness of the CDW role in mental health provision and assess the additional value the role brings to the mental health system. However, there is little other than anecdotal evidence of the impact of the CDW role. The research has identified a number of reasons why the role is not as effective as it could be, and these have been clearly rehearsed throughout the report and its findings. But this does **not** mean that the role has no value – far from it. Rather, it means that measures will need to be taken to better monitor the impact and added value of the CDW function in the future. Without this effective commissioning will be a continued challenge.

***Tackling Health Inequalities: 10 Years On (DH, May 2009)***, is a review of Health Inequalities in society conducted by Professor Michael Marmont. The review identifies some challenges and lessons for the Health Sector:

*"The distinction between policy design and implementation can be a fine one. Effective policy needs to build in mechanisms to help navigate barriers to implementation if it is to work on the ground. Individual and local organisations need to be clear about what the strategy asks of them. This means building in joined up action, nationally and locally, vertically and horizontally. It means challenging the structural barriers in the organisation of policy and service delivery ('silo working') to promote a cross cutting approach. For health inequalities these barriers include a lack of effective mechanisms to promote practical joint working between interested organisations, most obviously in the links between local authorities and the NHS at local level"<sup>13</sup>*

The future commissioning of CDW activities provides a real opportunity to recognise some of the barriers outlined in this excerpt from the Marmont review that have limited CDWs' role and function and to put in place the mechanisms to support the role more effectively.

CDWs have to be seen within the context of the whole system if the role is to have any opportunity to create impact. This means that any commissioning framework will need to take account not only of what CDWs do in their role, but how others support them to do it and the expectations that this will create in a system. This would be quite a complex commissioning brief, but one which is very much in keeping with the theory behind world class commissioning.

It also provides commissioners with another opportunity to think through whether this is the most effective way of engaging and supporting the community and to review other types of interventions which may make a difference.

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<sup>13</sup> *Tackling Health Inequality: 10 Year On* , DOH May 2009

In the end this report seeks to help clear muddy waters but with many notes of caution. This research has described the challenges involved in developing any kind of 'framework' for how the usefulness of the CDW function is evidenced and the direct impact it has on mental health services and service-users.

Some of the information needed to work out how effective the CDW role is requires people to report on how they 'feel'. Feelings are difficult to measure and assess in terms of monetary value. However, it is these 'feelings' that are important in judging the value of the service and reducing 'cycles of fear' amongst potential service users.

Current thinking around what 'BME communities' are and their needs are ultimately not sustainable in the long run. Communities change – indeed, it is essential that they do if they are to survive and be healthy. The CDW role must also respond to social, demographic, attitudinal and other changes within and outside BME communities. If geographical mobility is an option open to us all, then 'static' views of BME communities - that see them as staying in one place or all requiring services in the same way – may be not only short-term and unsustainable, they may also be inadvertently discriminatory.

This report has provided some strong arguments for developing mainstreamed changes to BME mental health services. Improving the effectiveness of the CDW function is only a part of this and achieving this part is intimately connected to improving other areas of the healthcare system. For example, improving the effectiveness of commissioning and CDW interaction with other healthcare professionals is also integral to improving outcomes for BME communities.

The NHS constitution makes strong commitments to developing a service which moves beyond taking account of equality and diversity to making guarantees around human rights. This provides a strong platform for unpicking the legacy and impact of previous approaches to race equality in mental health. Re-examining assumptions of what good race equality practice looks like will need to be part and parcel of any improved process for commissioning effective community development functions and activities.

[brap, January 2010](#)

# APPENDICES

## APPENDIX 1



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### COMMUNITY DEVELOPMENT WORKERS (CDW)

### ROLES AND OUTCOMES QUESTIONNAIRE

To help brap to review the role of CDW’s in the Yorkshire and Humber area, we have put together the questionnaire below which we hope you will be willing to complete. It important that you answer all questions as fully as you can. As you type into the boxes they will expand to accommodate your response. Once complete return to [selinam@brap.org.uk](mailto:selinam@brap.org.uk)

### SECTION ONE

#### About You

Name: (optional) \_\_\_\_\_

I would be happy to be interviewed by brap for further information

Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Job Title:	Post: Full time <input type="checkbox"/> Part time <input type="checkbox"/>
Area served:	Age Range: 16 – 25 <input type="checkbox"/> 26 – 40 <input type="checkbox"/> 40 – 54 <input type="checkbox"/> 55+ <input type="checkbox"/>	<b>Length of time your in post:</b>  Less than a year <input type="checkbox"/> One to 3 years <input type="checkbox"/> Over 3 years <input type="checkbox"/>
<b>Ethnicity</b>		
<b>Mixed</b> <input type="checkbox"/> White and Black <input type="checkbox"/> <input type="checkbox"/> Caribbean White <input type="checkbox"/> and <input type="checkbox"/> Black African <input type="checkbox"/> White and Asian	<b>White</b> <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background	<b>Asian or Asian British</b> <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian
<b>Black or Black British</b> <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black background		

<input type="checkbox"/> Any other mixed background		background within	
<b>Other ethnic groups</b> <input type="checkbox"/> Chinese <input type="checkbox"/> Any other ethnic group – please state			

1. What is your professional background?

*(Your previous job title may be sufficient)*

2. How prepared were you for the job of a CDW?

3. Do you feel that you have the skills and knowledge necessary for carrying out the role a CDW?

## **SECTION TWO**

### **On The Job**

1. What would you say was the main purpose of your role?

2. What do you spend most of your time doing?

3. What aspect of your role do you think you have been most effective in carrying out?

4. What do you think is the most important skill a CDW should have?

5. What kind of person is best suited to be a CDW?

6. What does community development mean to you?

7. What are the most difficult aspects of doing your job?

8. What are the easiest aspects of doing your job?

9. What 2 changes would you make to the role of a CDW? Say why you would make these changes.

### **SECTION THREE**

#### External Relations

1. Who do you think you have the most contact with?

• potential service users	
• carers	

• clinicians,	
• community organisations?	
• Other – <i>please state</i>	

2. Tell us whether you have you any clinical engagement e.g. doctors, nurses, social workers etc.

Regularly	
Sometimes	
Never	

3. Can you name 2 or 3 clinicians that you work with?

Name	Location

4. How well do you think the people you work with understand your role?

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5. Use this space to comment further on any issues, to do with the role of a CDW, that this questionnaire has raised for you.

***Thank you for your time***

## PROMPT QUESTIONS (FOCUS GROUP AND INTERVIEW)

### ROLE?

- How do you determine your objectives and priorities for the CDW role  
*Organisation /self/service users/ others?*
- How do you measure the progress against any objectives that are established?

What methods do you use to understand the impact your role is making?

### IMPACT?

- Prompt for Examples of performance measures
- Impact on service users ( trace inputs and outputs )
- What would have happened without your intervention?

### OTHER EXAMPLES ?

- **Ask open questions**

## APPENDIX 2

### Job Description

#### **BARNSELY BLACK AND ETHNIC MINORITY INITIATIVE (BBEMI)**

#### **Post Title: Community Development Worker**

To provide a resource for the organisation's activities, with particular reference to Barnsley BME community.

Responsible to:	BBEMI Community Development Manager
Responsible for:	Staff or Volunteers as instructed
Salary:	Up to 23, 993 (pro-rata) + Pension (8% of salary)
Hours:	Up to 37.5

#### **Main Areas of Work with Duties and Tasks**

1. To work in partnership with statutory providers, independent organisations and community to support the development with mental health problems in the BME community
2. To review current services, identify needs and ensure development of new and innovative approaches to improve access to mental health services.
3. To work with the provider organisations to identify training needs to facilitate the development of knowledge, skills and positive attitude in their staff.
4. To identify the mental health promotion needs within the BME Communities.
5. To develop capacity within the BEM community to promote their own mental health and well being through self help approaches.
6. To promote access to relevant services through the provision of information, support and advocacy.

7. To work with individuals and their care co-coordinator to ensure individual's needs are met.
8. To apply community development principles when devising methods of engagement as a means of removing barriers and encouraging dialogue.
9. To engage in dialogue and promote collaboration between the diverse communities to share experiences and develop common goals.
10. To work collaboratively with other Community Development Workers locally and regionally to achieve commitment and high quality outcomes.
11. To provide ongoing reports as specified by the Mental Health Board on Community needs, uptakes of and barriers to access and engagement with mental health services.
12. To work within BBEMI's policy framework, paying particular attention to promoting equal opportunities, a health and safety culture and good employee relations.
13. Report to BBEMI's Directors and other meetings as required.
14. Participate in appropriate training courses as required
15. Carry out any other related duties as agreed with the BBEMI Community Development Manager.

**BBEMI  
PERSON SPECIFICATION**

<u>ATTRIBUTES</u>	<u>ESSENTIAL</u>	CRITERIA TEST	DESIRABLE	DESIRABLE RANKING CRITERIA
QUALIFICATION, TRAINING AND EXPERIENCE	<ul style="list-style-type: none"> <li>• Experience of working within BME communities</li> <li>• Experience of carrying out needs assessment and developing action plan</li> <li>• Experience of facilitating the delivery of training</li> <li>• Experience of writing reports</li> </ul>		Educated to degree standard	
DISPOSITION, SKILLS AND ABILITIES	<ul style="list-style-type: none"> <li>• Demonstrate a commitment to improving the mental well being of individuals for diverse groups</li> <li>• Excellent written communication and interpersonal skills</li> <li>• Knowledge of and sensitivity to a wide range of cultural and religious issues</li> <li>• Knowledge of the impact of BME culture on mental health status</li> <li>• Ability to work effectively with staff at all levels within a range of organisations</li> <li>• Understanding of community development work with a BME community</li> <li>• Knowledge and understanding of the statutory, voluntary and independent mental health organisations</li> <li>• Understanding of a commitment to equal opportunities and anti-discriminatory practice</li> </ul>		Bi or multi lingual  Experience of using IT	
CIRCUMSTANCES	<ul style="list-style-type: none"> <li>• Ability to work flexibly and independently</li> <li>• Ability to travel independently within and outside Barnsley</li> </ul>			

Criteria test: A – Application Form                    I - Interview            T - Test            P - Presentation    R - Reference  
Please note the desirable ranking criteria are ranked in numerical order, number one ranking the highest.