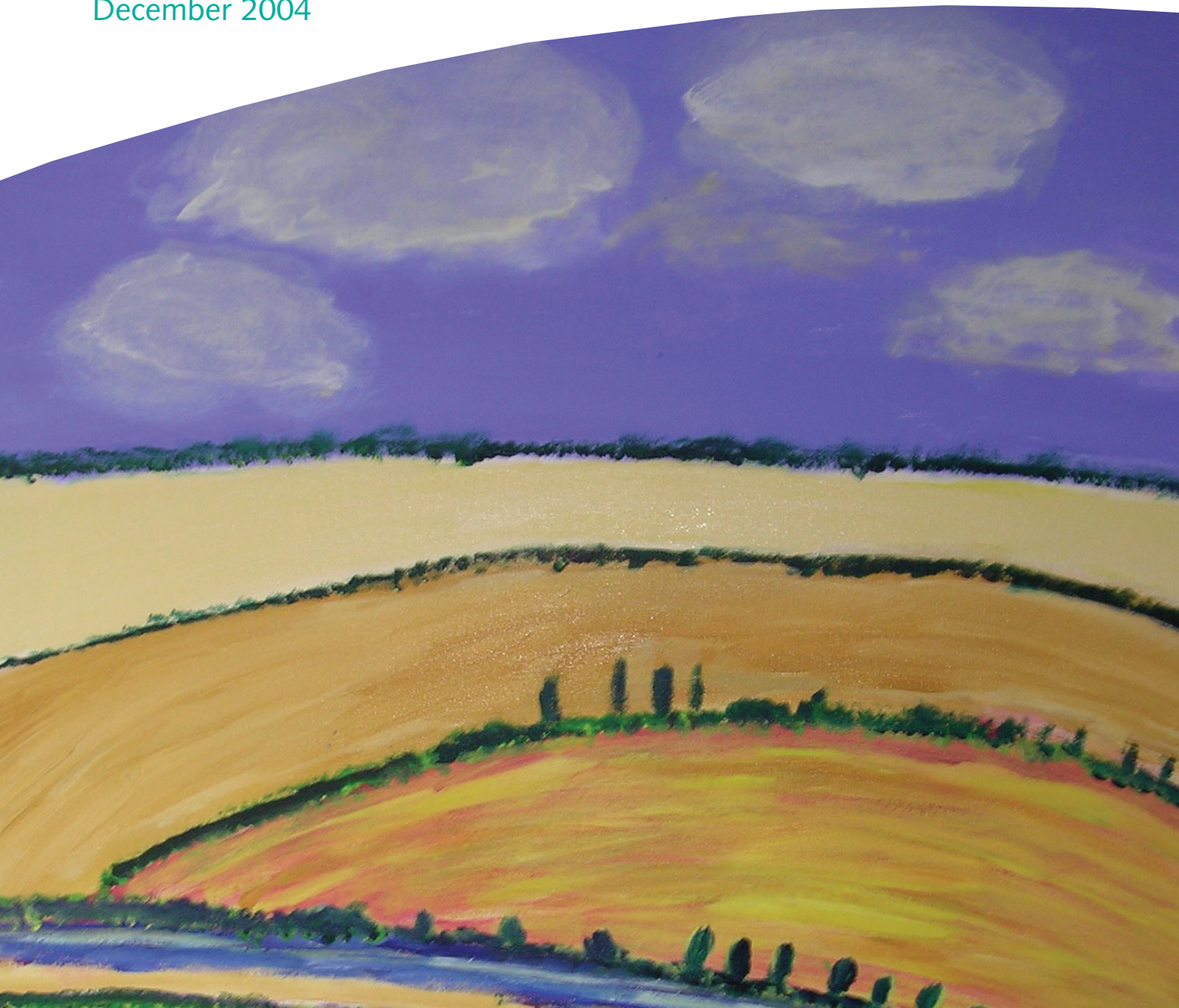


Mental Health Policy Implementation Guide

Community Development Workers for Black and Minority Ethnic Communities

Interim Guidance

December 2004



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**Community Development
Workers for Black and Minority
Ethnic Communities**

Interim Guidance

December 2004

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HR/Workforce	Performance
Management	IM & T
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For Recipient's Use	

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Introduction

Purpose

1. The purpose of this Interim Guidance is to provide a framework for local health and social care systems to introduce Community Development Workers (CDWs) into the mental health workforce in accordance with the Department of Health target to employ 500 CDWs by December 2006. The guidance should be read in conjunction with *Delivery Race Equality*¹, *Inside Outside*² and *Delivering Race Equality in Mental Health Care*.³

Responsibility

2. Primary Care Trusts (PCTs) are responsible for meeting this target. To do this, PCTs are advised to work collaboratively primarily with Strategic Health Authorities (SHAs) (see Appendix F) and other stakeholders in their local mental health and social care system, developing a project and securing 'sign up' from this group.
3. Other key stakeholders will include:
 - Mental Health Trusts (MHTs)
 - Local Implementation Teams (LITs)
 - PCT Public Health and Health Promotion lead(s)
 - NIMHE Development Centres and Race Equality Leads
 - Mental health service providers (voluntary and statutory sector)
 - Local Authority Social Services, Housing, and Education
 - Voluntary sector groups
 - Black and Minority Ethnic (BME) service user and carer groups
 - Government Office of the Regions

1 *Delivery Race Equality: A Framework for Action: Mental Health Services – Consultation Document: October 2003: Department of Health publication number 33247*

2 *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England: January 2004: National Institute for Mental Health in England publication number 29357*

3 *Delivering Race Equality in Mental Health Care and the Government's response to the independent inquiry into the death of David Bennett: An Action Plan for Reform inside and outside survey.*

Aim

4. The aim of introducing CDWs is to enable greater understanding and ownership of the issues facing people from BME communities so that real improvement takes place in the commissioning and provision of mental health services across the full age range. CDWs will work to ensure full participation and greater ownership in the development of effective health and social care with BME communities themselves recognising their experiences and reflecting their aspirations.

Interim guidance

5. As there are number of issues that require further detailed work and clarification, mainly around the education and training pathway, this is interim guidance. These and other issues such as learning from the experiences in setting up CDW Early Implementer sites will be covered in the revised guidance scheduled for publication in 2005. In addition, the development of mental health services and staffing of those services are subject to a dynamic process. There exists a variety of deeply held views on the best way of improving services for groups who have previously received poor quality provision. It is essential to recognise and reflect positive or innovative practice as it emerges.
6. The guidance is not prescriptive – rather it provides a framework for development that recognises the Shifting the Balance of Power initiative and the importance of local decision making. It provides provide sufficient key information to allow PCTs, working with their local stakeholders, to recruit CDWs now, taking a global view across the SHA patch to include not only a mental health but also a broader public health perspective to this work. The role of a CDW is a brand new one and it must not be seen as simply re-badging of any existing workers simply to fit the role.
7. A key requirement will be to identify where BME populations live and are in the greatest numbers, languages spoken, those failing to access services and why, those compulsory detained under the Mental Health Act and other specific issues. The identification of BME populations includes white minority communities such as those of Irish or other European communities. Details from the BME Mental Health census should be helpful.
8. CDWs should be deployed where the needs are greatest using the monies that are built into individual PCT baselines to best effect across a locality. The work of the CDWs will then help to shape the community strategy for their BME communities as part of the Local Strategic Partnership (LSP) to develop appropriate community services.

Early Implementer Sites

9. Acknowledging the consultation responses to the introduction of CDWs [see Appendix H], and the need to ensure a considered development of the role, a phase of early implementation has been planned.
10. A number of Early Implementer sites for CDWs are being identified, and are being developed in partnership with the Changing Workforce Team through the NIMHE Development Centres. Race Equality Leads (RELs) and local steering groups will work together to identify and support these Early Implementer sites, so that lessons can be learned for wider recruitment. The learning will influence the revised guidance to be issued in 2005.
11. It is intended that for this first cohort of CDWs, particular attention will be paid to the most appropriate form of supervision and support, personal development plans and appraisal. Education and training of this cohort will be co-ordinated nationally, through the Changing Workforce Programme.
12. This early implementation approach will form a part of the wider Delivering Race Equality programme implementation plan, outlined in the consultation document *Delivering Race Equality: A Framework for Action*.

Links to the NIMHE BME Programme

13. The development of CDWs is part of a much wider programme of work aimed at tackling the inequalities faced by BME users of mental health services. The overall programme of work was set out in the consultation document *Delivering Race Equality: A Framework for Action*.
14. The document concentrated on achieving improvements in three generic areas of services. The three generic 'building blocks' fundamental to the successful delivery of improved outcomes and experiences are:
 - Better quality and more intelligently used information
 - More appropriate and responsive services
 - Increased community engagement.
15. As Delivering Race Equality explains, these are complementary and all are necessary if the required improvements are to be made. Without community engagement it will not be possible for individual care plans/treatments, and local services, to be

designed around and capable of meeting the needs and aspirations of all racial and cultural groups within the local community. Community engagement will also improve the quality of the information available to commissioners and providers. This will enable them in turn to make services more appropriate and responsive to BME communities, thus making the latter more willing to engage with services. Action to improve information, make services more appropriate and responsive and increase community engagement should create a virtuous circle capable of replacing the 'Circles of Fear'⁴.

16. CDWs are a core part of increasing community engagement by supporting the development and exchange of information, knowledge and skills between mental health services and the communities they serve.
17. A revised version of Delivering Race Equality will be available in early 2005.³

Community Engagement Projects

18. The aim of the Community Engagement approach, based on a model developed by the Centre for Ethnicity and Health, University of Central Lancashire⁵ is to create an environment where BME communities and the statutory sector health and social care system can work together in order to design, develop and deliver more equitable services. It is intended as a catalyst for on going and sustained dialogue between agencies and the populations they serve. It aims to build capacity in BME communities, the voluntary sector and in the statutory sector, promoting social inclusion, cohesion and regeneration.
19. Developing work with communities is a key element of work within the NIMHE BME programme. Over the next two years, NIMHE would like to identify innovative mental health projects from voluntary and community organisations with good links to BME communities. The projects may have an impact on access to care, mental health awareness or satisfaction with mental health care. It is also expected the process of setting up and evaluating these projects and securing longer term funding will increase the general input of BME communities in service development, increasing the levels of engagement of the community in mental health services and develop lasting links between the statutory and non-statutory sectors.

⁴ Breaking the Circles of Fear (2002): SCMHE

⁵ Community Engagement Report 1 – The Process Winters M & Patel K University of Central Lancashire and Department of Health

20. NIMHE would like to fund 80 community engagement projects across England over the next two years. The RELs based in the NIMHE Development Centres (see Appendix G) and a specialist national team will support these projects.
21. These projects may provide a fertile recruitment pool for CDWs but it is neither the sole or primary purpose of the projects to “provide” CDWs or employ them.
22. Further details of the Community Engagement Projects can be found on the NIMHE web site (www.nimhe.org.uk) and the NIMHE Knowledge Community web site <http://kc.nimhe.org.uk>

Guidance

Role

What is the role of CDWs?

1. The role of the CDW may well vary according to local community needs but there are likely to be four key functions defining any CDW role. These are:
 - *Change Agent* eg by identifying gaps; developing innovative practice
 - *Service Developer* eg promoting joint working, education and training
 - *Capacity Builder* in BME communities
 - *Access Facilitator* to services; community resources; overcoming language and cultural barriers.

This is set out in diagrammatic form in Appendix A.

Community development: building on strengths

2. Community development or capacity building within particular communities is not a new idea. In different contexts, similar themes have been pursued around enhancing communities' ability and preparedness to deal with social or health problems, and in forging a harmonious relationship with agencies across the voluntary, independent and statutory sectors.
3. In this instance, the main aim is to build on the inherent strengths in and with BME communities themselves. The idea that communities and individuals should reclaim their responsibility and ownership for their health and health care has its roots in both self-help and public health movements, as well as in the cultural traditions of many minority ethnic groups.

Informing change and improvement

4. Community development, in this context, goes beyond establishing a 'link' between communities and governmental agencies. It goes beyond establishing ways to enhance the engagement of communities in given programmes or initiatives around health or welfare. CDWs will help to improve the experience of people from BME groups when they access mental health services. They will help to reform mental health services: investment in CDWs will enable mental health organisations (both within statutory and voluntary sectors) to bridge the gap between Western models of care, and the values and norms of the communities they are serving.

Promoting inclusion and access

5. A key role will be to facilitate community participation and ownership for people from BME groups. CDWs will support community groups to help them operate effectively, and to direct them to information, development opportunities, resources and funding sources.
6. The investment in CDWs will be a significant step towards achieving an inclusive approach in dealing with health inequalities both at the community and service level, in line with the national public health and social inclusion agenda. It is essential that the potential for CDWs in highlighting and tackling health inequalities is clearly understood by LSPs and the wider mental health system. The success of the CDW role will be dependent upon local strategies that support the involvement of local BME communities in mental health and social care service planning and development.
7. CDWs will contribute to:
 - **Seeking out strengths and abilities** within local BME communities to help them to manage and address mental distress, deal with social and cultural stresses contributing to mental illness, and explore how such approaches could be used in a holistic and culturally sensitive ways to manage mental health problems.
 - **Supporting community development:** helping groups and individuals to identify needs and concerns, and work out local solutions. Identifying stakeholders, organising groups, working with volunteers.
 - **Supporting local groups and networks** so they can be partners in developing and improving mental health and social care services
 - **Developing leadership** locally, creating training and development opportunities; delivering training and development.
 - **Developing the skills, knowledge and confidence** of individuals and communities to enable them to create local solutions.
 - **Signposting people to information, resources and sources of funding** so that local residents can take action to meet their own needs.
 - **Identification and promotion of people** applying to undertake new roles created by the the draft Mental Health Bill⁶ including independent Mental Health Advocates, members of the Mental Health Tribunal and members of the Expert

6 Draft Mental Health Bill: Department of Health 2004: Cm 6305-1 and 6305-11

Panel (who will provide advice to the Tribunal in cases dealing with compulsory powers under Mental Health legislation).

8. The success of the CDW role will be dependent on the worker(s) being linked formally to local partnerships and organisational structures. Support, supervision and co-ordination of CDW activities require discussion and detailed planning, locally. Similarly, community developments will need to be connected to other service development priorities within mental health.

So what is the role not about?

9. The CDW role is not about:
 - Being an expert or leading on all matters to do with BME issues
 - Being a clinician or care provider eg providing clinical or medical treatment or therapeutic services; monitoring or administering medication or sectioning or compulsory medication/treatment under the Mental Health Act
 - Service management
 - Care co-ordination under the Care Programme Approach/Care Management
 - Re-badging existing roles
 - Supporting a particular service model
 - Propping up services that do not meet the need of BME communities.

How will CDWs operate

If CDWs are not to be seen as part of the service model in a mental health provider, how do they fit in with the provision of services?

10. CDWs will provide a resource and a supportive link between BME communities and mental health services. They will be independent of any particular service or professional model so they can help to promote confidence amongst BME service users and carers and the wider community. CDWs should enable a clearer articulation of the mental health needs of BME communities to be made that leads to a process of change and improvement in services.

What impact are CDWs going to have?

11. CDWs have an important role, which has strong links to the social exclusion agenda⁷, is to provide help and support to BME groups and communities and to mental health services. Their impact will be an improvement in the commissioning and provision of mental health services across the full age range that are fair and equitable that fully reflect the needs and aspirations of those who use them, particularly those who have experienced institutional discrimination. Work needs to be done at the organisational, team and individual practitioner level to ensure that there is a clear understanding and appreciation of the importance of the CDW role in helping in the delivery of more appropriate services to diverse communities.

Can you give an example of where this might happen?

12. One example might be where a hospital admits a significant number of young Pakistani women for severe loss of weight, attempted suicide and deliberate self harm. The hospital staff have become aware that the patients and their families have little knowledge about being referred to mental health services and what this means.
13. The hospital staff tell the CDW what is happening and as part of their role in community development, the CDW:
 - ensures hospital staff are aware of and adopt a culturally competent and sensitive approach to assessment, care and treatment
 - informs the hospital staff, patient and family of appropriate support that can be accessed from the community during the period of admission
 - informs patients/families of their rights and access to support and information
 - works with hospital staff to identify the range of needs on discharge and support required
 - helps patients and families to provide feedback about their views of the service received and views about any improvements.
 - provides feedback to the local commissioners and providers so they can take account of relevant issues with a view to developing and sustaining a culturally competent workforce and services.

⁷ Mental Health and Social Exclusion: Social Exclusion Unit Report: Office of the Deputy Prime Minister (2004) www.publications.odpm.gov.uk

How will CDWs help individual service users and their carers?

14. Although CDWs will help individual service users and carers, this is not their primary function. Individuals from BME communities are experts in their own care and as such, they can most often guide the CDW about ways in which they would like to be helped and supported.
15. CDWs could help service users and carers in a variety of ways. Through signposting:
 - they will help to connect the individual with local communities by making sure that families, friends, carers etc know their help may be needed thus helping to overcome social exclusion
 - they will help to connect the individual with both the voluntary and statutory sectors thus promoting as wide a range or network of support as possible
 - they will help to connect the individual with local resources whether that be for help with finances, support and time, clinical services, housing, employment etc

What about maintaining confidentiality?

16. The CDW will maintain strict adherence to current guidance on confidentiality. It is important to recognise that in making connections, the CDW is not necessarily doing this on behalf of the service user but is empowering the service user to do things on their own behalf with adequate and appropriate support, working with family, carers and friends.

What about people becoming dependent upon CDWs?

17. CDWs are there to help individuals move along a pathway away from dependency upon others and organisations towards independence. They will do this by encouraging and supporting the local community in all its' forms to provide a network of support, advice and where appropriate, services, that meets the individual needs of service users. This may be seen as community capacity building.

How will BME service users and their carers or families get access to CDWs?

18. From a variety of sources. As the role of CDWs becomes known, the contact details will be available from a wide cross section of localities such as community centres, religious and cultural settings, GP surgeries, PCT or MHT lists of community and other support etc. And by word of mouth of course.

Getting Started

19. Prior to the recruitment of the CDW, and with the involvement of LITs, it is important that localities have some understanding of the needs and issues faced by the BME communities they are serving. Clearly, where localities have undertaken some specific needs assessment work, they can begin to make informed decisions about the most effective way that the role can be utilised and the most appropriate location for the post. Other localities will need to build upon specific local studies to develop an understanding of the population composition in terms of ethnicity, language, culture, socio-economic and geographic factors. For example, local data would need to be obtained regarding current access to services, use of the Mental Health Act, use of in-patient services, length of stay in hospital, use of community based services, use of talking therapies, and the wishes and needs of BME communities amongst other issues.
20. The work undertaken through the CDW role should be regarded as one part of the local action responding to the identified mental health needs of BME communities. Their work should be 'owned' by stakeholders, as set out in the Introduction as part of the LSP. An appropriate stakeholder group should govern the delivery of the project. Not only will this affirm the importance of the agenda, but it also raises the profile of the CDW role and its work.
21. A coherent strategy for participation of the various stakeholder groups in BME mental health services should be devised, having a particular focus on BME service users and carers. The participation strategy could cover such areas as:
 - Shaping the role and function of CDW roles
 - The most appropriate host organisation to employ a CDW
 - Practical arrangements for the location and support of CDW's
 - Mechanisms for accountability of CDW's to BME communities
 - Identification of BME community concerns and gaps in local services
 - Focusing down on immediate steps for improvements in services
 - Plans to implement improvements in a participatory way
 - Assisting the CDW to be effective in monitoring and evaluating service quality for BME communities

- Ongoing liaison and support by BME communities for CDWs
 - supervision/mentorship arrangements
 - reporting arrangements regarding work plans (ensuring realistic and deliverable timescales)
 - clarity around training and development opportunities
 - describing relationships with any existing workers with similar roles
 - responsibilities for and the shape of the induction programme
 - and identifying resources needed to support the post
- 22. This approach will encourage BME communities to have an increased sense of ownership and engagement with the new CDW posts and greater direct participation in the work of the CDW.
- 23. The sort of questions agencies should ask themselves about getting started and the recruitment of CDWs are set out in Appendix B. Some examples of a potential job description and person specification are set out in Appendix C.

Recruitment and Retention

Where will CDWs come from?

24. CDWs will come from different walks of life and from many diverse backgrounds including volunteers, current and former users and survivors of mental health services. CDWs will have different educational and social backgrounds, personal experiences and qualifications. What will unite them however, is a strong commitment, desire, and the ability to increase the well-being of those in the BME community and so make a difference to their lives.

Do CDWs have to be recruited from BME communities?

25. No. But what they must do is to work with, on behalf of and closely with the BME community. There may, however, be compelling reasons why it is felt necessary for a worker to be employed from a particular ethnic background, but this is likely to be the exception and would need to be compliant with the Race Relations Act. Appendix D sets out some advice about this that employing bodies may wish to consider.

How will the Early Implementer sites help with recruitment?

26. Early implementers of CDW roles will provide important information about the most effective way to recruit CDWs, ensuring the posts are attractive to the widest range of candidates.
27. Various recruitment methods will be explored and evaluated in the Early Implementer sites, for example, introductory or information days, practical assistance in filling in application forms, and where appropriate, advice about issues such as impacts on benefits status.

What issues should be considered in recruiting CDWs?

28. It is very important that anyone interested in becoming a CDW is able easily to access information about the post, and is supported in their application. This applies particularly where a person does not have English as their first language or may experience dyslexia, communication difficulties or sensory impairments.
29. It is important to emphasise the value of ‘expertise by experience’ of service user/survivors and families/carers in recruitment procedures.
30. Arrangements for flexible working, job-sharing, allowances for carers leave and parental leave and other good employment practices can greatly enhance the attractiveness of these posts as well as the quality of working life for CDWs.

Who should employ CDWs?

31. It could be any employer in the health or social care field, in the voluntary, private or independent sector. The funding for these posts lies within PCT baseline allocation, and models of employment will need to be developed with this in mind.
32. There may be a range of employment options. In no particular order or “ranking”, these might include:
 - employment by a PCT
 - employment by a PCT with the LIT acting in an advisory capacity
 - employed by a Local Authority
 - employed by a voluntary sector organisation
 - employed by a MHT.

Support and management of CDWs

What support should CDWs have?

33. Working with the existing management hierarchies and reporting mechanisms of their employer, CDWs should be supported by a named senior officer. For example, this could be a Trust Board member or the Chief Executive of the organisation. The precise nature of these arrangements will need to be negotiated locally. In addition, assuming the employment of a CDW is by a PCT/MHT, a CDW should have a direct reporting function to the Trust Board so that the top of the organisation is aware of, signed up to and supportive of their role.

What on-going support and supervision should a CDW receive?

34. CDWs will be working to a great extent on their own out in the community. Whilst it is anticipated they will be both self sufficient and resourceful people, they will need regular, support and expert supervision. This may be identified, facilitated or identified by the RELs and should comprise of:
 - the ability to reflect on the issues involved in their work
 - the opportunity to discuss their work and how they are going about this
 - for their performance to be monitored
35. Every opportunity should be taken to enable CDWs to meet together to share experiences and intelligence as well as good practice and for mutual support. overcoming barriers to improving practice in local services for BME communities.
36. Supervision is the key to risk management in mental health and to personal learning and development. Mentoring and coaching for CDWs should be offered wherever possible as these methods are proven, effective ways of enhancing and developing the job skills of any worker. Group supervision and action learning techniques could prove to be useful methods of providing on the job learning opportunities for CDWs.
37. The role is potentially demanding. CDWs and their supervisors need to manage workloads carefully and ensure that supports are appropriately available. Supervisors and CDWs should ensure that within the supervision process there is the opportunity to reflect upon the emotional impact of the role upon the individual worker and then consider how this can be best managed.

Career progression

What might a CDW expect to be in place to help them develop and progress their career?

38. This might take several forms. As in other walks of life, some CDWs will be content to remain with their existing role. Others will wish to progress but the key thing is 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 CDWs must fully embrace such change and diversity based on continually up-dating their knowledge and skills.
39. Work is currently taking place to develop “A Career Framework for the NHS”⁸ and this will need to show where CDWs fit in to a career pathway. The Framework is not confined to NHS staff but includes social care roles as well. Further information will be included in the revised guidance due for publication in early 2005.

Terms and Conditions

Are there any registration or regulatory requirements for CDWs?

40. For those working as part of the social care workforce, the General Social Care Council (GSCC) will, over time, register all those who wish to work in the social care field. The Council will determine the registration criteria for particular groups in the social care workforce as the times comes for them to register. It is likely these will include some form of accredited qualification or evidence of competence having been attained as well as other evidence of suitability for entry onto the social care register. People will be required to renew their registration periodically. The criteria for this will include the person undertaking continuing professional development.
41. The important thing to note is that the ability to be able to work in the social care sector as an individual as part of a particular type of workforce will be dependent upon being accepted and registered by the GSCC. The GSCC has issued Codes of Practice for social care workers and employers (www.gsc.org.uk) which describe the standards of conduct and practice within which social care workers and employers should work.

⁸ A Career Framework for the NHS: Discussion document, version 2, June 2004. Available from career.framework@dh.gsi.gov.uk

42. The NHS is setting up a regulatory process for all qualified and non-qualified staff that will include new roles. For those CDWs who are to be employed in the NHS, Trusts will need to use the clinical governance process to ensure robust supervision and support mechanisms are in place. In future, if the CDW role becomes established with nationally-agreed competences and training, it may be statutorily regulated possibly by a healthcare regulator working with the same principles and requirements as the GSCC. The intention would be that registration with either GSCC or a healthcare regulator such as the Health Professions Council would be based on the same standards and therefore acceptable for employment in both health and social care settings so that dual registration would not be necessary.
43. All staff who work directly with children and young people under the age of 16 are required to be 'police checked'. Staff will also be expected to undertake 'In Service' training on child protection issues so that they are clear about local policies and procedures. Arrangements for training are organised by the local Area Child Protection Committee though the terminology is moving to 'Safeguarding' Boards. Social Services are the lead agency for all of this but each NHS Trust has to have a nominated doctor and nurse for child protection and Board level responsibility for this issue.

What levels of pay should CDWs receive?

44. The current level of funding included in PCT baseline allocations provides for a salary of £25,000 and the normal "on-costs". This is calculated with reference to the target of 500 CDWs being in place by December 2006. It is, of course, open to local employers to pay a higher salary if they believe it is justified on the grounds of experience, qualification, experience, degree of responsibility etc but any sum over and above the indicative sum above, will have to come from their own resources.

Education, Training and Continuing Personal Development

What induction should CDWs receive?

45. CDWs will need appropriate local induction and additional specific induction which might include:
 - working with communities and organisations
 - how mental health services are organised and how they operate across NHS and social care

- understanding the experiences and needs of BME communities they will work with and support
- maintain safety at work including personal safety; assessment of risk; first aid skills; how to recognise and handle violence against staff
- the rules about confidentiality

What education and training should CDWs receive?

46. The Ten Essential Shared Capabilities (ESC)⁹, will provide the building blocks for a social model approach to mental health to include service user participation and the principles of an holistic service.
47. The Ten ESC were developed in consultation with service users and carers together with practitioners, and set out the shared capabilities that all staff working in mental health services should achieve as a minimum as part of their pre-qualifying training. They are intended to make explicit what should be included as core in the curricula of all pre and post qualification training for professional and non-professionally affiliated staff as well as being embedded in induction and continuing professional/practitioner development. It has already been agreed that one of the Ten ESC, 'Respecting Diversity' [cultural competence] is a priority for development by NHSU.
48. Core training materials are being developed jointly between NIMHE, NHSU and the Sainsbury Centre for Mental Health (SCMH) around the Ten ESCs to be delivered in a variety of formats. Specific material on cultural awareness and cultural competence will run through this core programme. In addition, a more focussed training programme on 'Race Equality' in Mental Health will be delivered in collaboration with the 'Breaking the Circles of Fear' national programme (SCMH/NIMHE) and RELs from the NIMHE Development Centres. Specific material on race equality would be set alongside the Ten ESCs.
49. In addition, the CDW will need to have a good understanding of how institutional discrimination impacts upon BME service users and affects the way practitioners work. See Appendix E.

9 The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce: August 2004: Reference No: 40339.

50. CDWs should use practical and effective communication skills coupled with a understanding of the value of interpersonal relationships. This should be supported by regular supervision and monitoring.
51. Working with TOPSS and Skills for Health, NIMHE will be looking to develop an appropriate education and training pathway that will be set out in the full guidance to be published in 2005.
52. Initially, in common with other workers who use this as a basis of their education and training, employers may wish to consider that CDWs should have underpinning knowledge of mental health which can be provided by way of the Level 2 Certificate in Mental Health¹⁰ Work and the Level 3 Certificate in Community Mental Health Care¹¹.

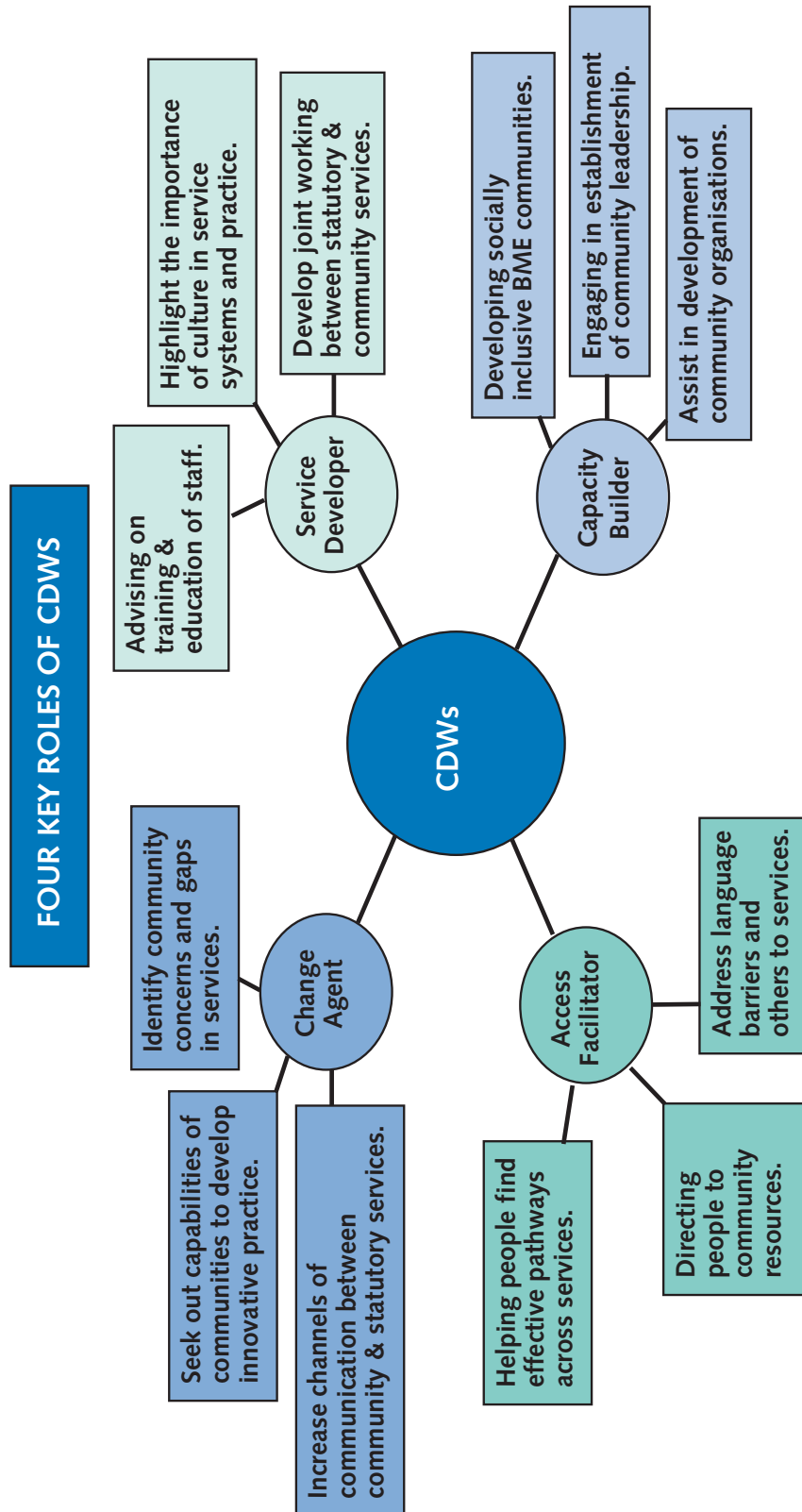
Further information

53. Further Information can be obtained from:
 - Regional Race Equality Leads (See Appendix G)
 - Early Implementer sites (Barry Foley – barry.foley@dh.gsi.gov.uk)

¹⁰ Level 2 Certificate in Mental Health Work: Pavilion Publishing www.pavpub.com

¹¹ Level 3 Certificate in Community Mental Health Care: Pavilion Publishing www.pavpub.com

Appendix A



Appendix B

Getting started – Questions for Agencies

- Who will take the lead for recruitment to this role within and/or across PCTs?
- Within your health and social care community, who are the key stakeholders and partners who should inform this work?
- Would collaboration across health and social care communities be desirable and possible? If so, what are the benefits to be gained?
- How will an analysis of local needs, priorities and opportunities be undertaken?
- How will local partners be engaged in the recruitment, deployment and evaluation processes?
- What would be the timescale for recruitment?
- What would be the training, development and supervision needs of the post holders?
- How will you ensure that the CDWs are recruited to viable roles, in hospitable and supportive environments?
- How would the role be introduced to and within the local community, and the wider mental health system?
- How would this development align with your:
 - Local Strategic Partnership
 - Local Delivery Plan
 - Community/Social Inclusion Action Plan
 - Race Equality Plan
- How would the role be evaluated?

Appendix C

Job Profiles

This Appendix contains two illustrative examples of Job Profiles to be adapted locally as necessary.

The first, on pages 24 to 27 is a suggested content for a CDW role working from **outside** Mental Health provider organisations such as from PCT's, social care or the voluntary sectors.

The second, on pages 28 to 31 is a suggested content for a CDW role working **inside** a Mental Health provider organisation such as a Mental Health Trust.

Neither is exhaustive and should simply be the start for local discussion and determination.

JOB PROFILE NUMBER ONE

CDW role working from outside Mental Health provider organisations

Job Title: Community Development Worker for the Black and Minority Ethnic Community-Mental Health

With added areas for scope of role

- Public Health Facilitator for Primary Care – Vulnerable Groups
- Community Development Worker – “Oxford City” PCT
- Service Development Manager
- Community Development Worker Asian Support Services

Department/Section: (to whom will they be accountable)

- Senior Public Health Manager, Public Health Team
- Lead for Mental Health – “Oxford” PCT Commissioning and Redesign Directorate
- Medical Director – Asian Services Directorate
- Asian Support Services

Reports to: See Guidance

Responsible to: See Guidance

Salary Range:

- £25,000 Suggested Benchmark (see guidance for further details)

Hours of work:

37.5 per week full-time [Maximum flexible approach to enable the widest field of applicants for part-time and job-share (pro-rata)] Role will include some weekend and evening work.

Location of the job:

- To be determined locally

Travel:

- Physically able to travel as part of the role (not necessarily a car driver)

Management Responsibilities:

- People and budget – arrangements will apply as and when necessary

Management Areas & Key Relationships. Links with:

- GP Practices, Social Services and voluntary agencies +
- Links with mainstream mental health services and other service development areas as well as public health and Primary Care services * +
- Work with Mental Health Matters Development Worker and the MIND 'Women of Colour' worker. * +

To link with the Black Workers Support Groups

Job Purpose/Summary

- Support Local Service Delivery +
- Work across PCT's to cover diverse and dispersed communities +
- To give advice and support to PCT's on migrant and refugee health issues +
- Ongoing identification, quantification and needs assessment of vulnerable groups, currently asylum seekers, refugees and other migrant ethnic minority groups +
- Facilitation of access to health services for vulnerable groups such as asylum seekers, refugees and other migrant ethnic minority communities +
- Providing information and facilitating delivery of appropriate training for health professionals including cultural awareness, issues specific to the communities being served and general issues on asylum seekers and refugees +
- Information sharing and collaboration between health, social services and voluntary sector with influence of strategic change when appropriate +
- Work with GP practices to incorporate identification of vulnerable groups, currently migrants, refugees, and asylum seekers, in patient records and provision of appropriate services and staff training when required +
- Encouraging use of interpreting services in primary care and contributing to their review +
- Mental Health Promotion and anti-stigma work in BME communities * +
- To flexibly work/adapt local strategies to improve services for BME communities
- To review current services, identify needs and ensure the development of new and innovative approaches which will improve culturally and linguistically sensitive services that improve access. Provide effective support, treatment and care and deliver better mental health outcomes for people from the BME community +
- To work in partnership with statutory providers, independent organisations, religious leaders and communities to support the development and provision of an integrated service that brings together opportunities for improved health, social care, housing, income, work and leisure to meet the needs of people with mental health problems in the BME community +

- To work with staff in the Trusts and other provider organisations to provide leadership, to enable the development of knowledgeable staff within the service that have training, skills and attitudes to gain the confidence, respect and trust of the BME community
- To review current services, identify gaps in service provision from BME service providers, improve the capacity of BME organisations to deliver services which meet the needs of the BME communities that they serve +
- To work in partnership with statutory providers, independent organisations, religious leaders and communities to support BME mental health service providers and the statutory sector to facilitate innovations in service and improve service delivery to BME communities +

Personal Specification:

Good general education and a demonstrable ability to learn and apply knowledge

- Ability to communicate clearly, both verbally and in writing
- Flexible approach and ability to work independently and on own initiative
- Effective communication skills, both written and verbal
- Ability to deal with complex issues facing vulnerable groups in the community
- Good organisational and interpersonal skills

Experience:

- At least 2 years experience working with or for communities, either in the voluntary or statutory sector, including experience of working with the community groups relevant to the post
- Experience of working with people who may be distressed/displaced
- Experience of facilitating the delivery of training and making information available to a range of professionals
- Experience of working collaboratively with a range of agencies
- Carrying out needs assessment and preparing action plans

Knowledge:

- Demonstrate knowledge of the community groups relevant to the post, including excellent awareness of cultural, social and health issues
- Demonstrate knowledge of any languages spoken by the various community groups relevant to the post (where applicable)
- An informed and practical view of the role of a health advocate, including the public/health promotion aspects of the post
- Knowledge of health services, including primary care
- Understanding of public health issues
- Knowledge of community support and development

Specific Expertise:

Skills:

- The ability to work with a range of people in different settings, including professionals from statutory and voluntary organisations and members of the public
 - Experience of using IT (word processing, e-mail and the internet) – desirable
 - Ability to work independently and organise own workload
 - Ability to work across a range of organisations and stakeholders
 - Language skills?
-

Education and Training:

- Identify learning needs and undertake agreed training and development in connection with the role
- Help design, deliver and evaluate training on BME issues, service provision and developments

JOB PROFILE NUMBER TWO

A CDW role working inside a Mental Health provider organisation

Job Title: Community Development Worker for the Black and Minority Ethnic Community-Mental Health

Add additional title to suggest area of work

- Public Health Facilitator for Primary Care – Vulnerable Groups
- Community Development Worker – “Oxford City” PCT
- Service Development Manager
- Community Development Worker Asian Support Services

Department/Section: (to whom will they be accountable)

Examples:

- Senior Public Health Manager, Public Health Team
- Lead for Mental Health – “Oxford” PCT Commissioning and Redesign Directorate
- Medical Director – Asian Services Directorate
- Asian Support Services

Reports to: See Guidance

Responsible to: See Guidance

Salary Range:

- £25,000 Suggested Benchmark (see guidance for further details)

Hours of work:

37.5 per week Full-time [Maximum flexible approach to enable the widest field of applicants for part-time and job-share (pro-rata)] Role will include some weekend and evening work.

Location of the job:

- To be determined locally

Travel:

- Physically able to travel as part of the role (not necessarily a car driver)

Management Responsibilities:

- People and budget – arrangements will apply as and when necessary

Management Areas & Key Relationships:

- Links with mainstream mental health services and other service development areas as well as public health and Primary Care services * +
- To work with organisations such as Mental Health Matters Development Worker and the MIND 'Women of Colour' worker * +

To link with the Black Workers Support Groups such as African Caribbean Healthcare

Job Purpose/Summary

- To act as a link between health professionals providing clinical care and individuals from the relevant communities in the locality in order to offer effective support *
- To promote understanding of cultural issues and contribute to ensuring culturally appropriate service delivery *
- To promote understanding of the services provided, increase uptake and work to improve equality of access for people from the targeted community groups *
- To contribute to health improvement initiatives for the relevant community group
- Improving health for vulnerable groups *
- To identify, quantify and assess the needs of vulnerable groups *
- To lead and contribute to specific project work as required *
- Development of work programmes over time to meet the needs of other vulnerable groups as required
- To reduce and eliminate ethnic inequalities in mental health service experience and outcome; to support BME communities in dealing with mental health and mental ill health; to bridge the gap between western models of care and support early intervention and access to primary care services *
- Mental Health Promotion and anti-stigma work in BME communities * +
- That the roles exist to combat inequalities in mental health services, tackling acknowledged discrimination within services *
- To flexibly work/adapt local strategies to improve services for BME communities
- Responsible for the management of the BME and further development of the BME Services in order to create and implement ethnically sensitive components that better meet the needs of people from BME communities

- To work with existing staff in the Trust, providing leadership, to enable the development of knowledgeable staff within the service that have training, skills and attitudes to gain the confidence, respect and trust of the BME community
- To work to improve the level of skilled staff from a variety of Asian cultural, religious and linguistic backgrounds, reflective of local communities, working in the Trust *
- To work with existing staff in the Trust, providing leadership, to enable the development of knowledgeable staff within the service that have training, skills and attitudes to gain the confidence, respect and trust of the BME communities *

Personal Specifications:

- Good general education and a demonstrable ability to learn and apply knowledge
- Flexible approach and ability to work independently and on own initiative
- Excellent communication skills, both written and verbal
- Ability to deal with complex issues facing vulnerable groups in the community
- Good organisational and interpersonal skills

Experience:

- At least 2 years experience working with or for communities, either in the voluntary or statutory sector, including experience of working with the community groups relevant to the post
- Experience of working with people who may be distressed/displaced
- Experience of facilitating the delivery of training and making information available to a range of professionals
- Experience of working collaboratively with a range of agencies
- Carrying out needs assessment and preparing action plans

Knowledge:

- Demonstrate knowledge of the community groups relevant to the post, including excellent awareness of cultural, social and health issues
- Demonstrate knowledge of any languages spoken by the various community groups relevant to the post (where applicable)
- An informed and practical view of the role of a health advocate, including the public/health promotion aspects of the post
- Knowledge of health services, including primary care and social care
- Understanding of public health issues
- Knowledge of community support and development

Specific Expertise:

Skills:

- The ability to work with a range of people in different settings, including professionals from statutory and voluntary organisations and members of the public
- Experience of using IT (word processing, e-mail and the internet) – desirable
- Ability to work independently and organise own workload
- Ability to work across a range of organisations and stakeholders Language skills?

Appendix D

The Race Relations Act 1975

1. The Race Relations Act 1975 [the “RRA”] makes it unlawful to treat someone less favourably than you would treat another on the grounds of that person’s nationality, colour, racial, ethnic or national origins (referred to as their “race” for shorthand purposes in this Appendix), unless the discrimination is of a type permitted by the RRA. It is widely understood that the nature of the CDW role specifically deals with issues affecting BME communities and as a result, any CDW that is recruited should have an in depth understanding of what some of those issues are.
2. With a considered consultation process with BME service users and providers, the nature of the role and responsibilities of the CDW should inform the skills and experience required before recruitment. While the RRA permits an employer to specifically recruit people of a defined race to work with specific ethnic groups where a Genuine Occupational Qualification/Requirement applies, it is important that suitably skilled and experienced people are recruited who are able to work with a wide range of communities.
3. In some areas where consultation processes may determine that CDW’s should be recruited with the express aim of working with their own racial groups, then as long as it can be proven that they will be providing a personal service promoting their welfare and that an employee of the specified race is a proportionate means of providing the service, then an employer is legally permitted to discriminate in this manner and to do what local needs dictate. It would be wise for employers to check it through their legal services department if that is the route they decide to take.
4. It should be made clear that recruitment processes must follow equitable procedures and that an appropriately qualified and experienced CDW is employed, although it is also worth remembering that discrimination on the grounds of race can be lawful where Genuine Occupational Qualifications/Requirements apply”. As mentioned, it should be expected that anyone recruited is able to fully demonstrate their skill to work across ethnicities and races. Any good CDW should be capable of this task. But of course in some areas the tradition of supporting communities can and do take on different approaches and as a result it is envisaged that wide ranging consultation will take place before the CDW is in post and that however process of recruitment is undergone it will reflect the needs of the local community.

Appendix E

Education and Training – Putting the Ten Essential Shared Capabilities into practice for Community Development Workers

1. Working in Partnership

Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.

For CDWs this means...

Developing and maintaining working relationships between statutory and voluntary community services, especially BME groups and encouraging the direct participation of BME service users and their families including the development of mechanisms to achieve genuine BME participation. The CDW will need to work across all stakeholder groups in BME communities including service users, families, carers, Black voluntary groups, community groups, religious groups and BME service user/survivor-led groups.

2. Respecting Diversity

Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

For CDWs this means...

Facilitating culturally appropriate assistance and therapeutic interventions. The CDW will also need to ensure that they respect and value the diversity within BME communities in terms of race, culture, age, spirituality, disability, gender, sexuality and class.

3. Practising Ethically

Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.

For CDWs this means...

Recognising the rights and aspirations of BME service users and their families, in particular issues of confidentiality and the need to protect the reputation and status of people in their communities. The CDW will need to understand, protect the rights and promote the interests of BME service users within a context of institutional racism in mental health services and help to ensure that services are answerable to BME communities.

4. Challenging Inequality

Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in the communities they come from.

For CDWs this means...

Tackling discriminatory barriers and social exclusion of BME service users. The CDW will need to work for the social inclusion of BME service users within their own communities, counteracting stigma and discrimination and helping them to develop valued social roles that are meaningful to them.

5. Promoting Recovery

Working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.

For CDWs this means...

Taking an approach to recovery that promotes race equality and strengthens cultural identity. The CDW will need to take a holistic and positive approach to assisting BME people in mental distress to recover in ways that are culturally acceptable to them.

6. Identifying People's Needs and Strengths

Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users, their families, carers and friends.

For CDWs this means...

Ensuring that information about BME service users is gathered in an anti-discriminatory way and is relevant to the person in their cultural context which may require a good understanding of the person's wider social networks. The CDW will need to ensure that information gathered about the needs of BME people is set within a clear cultural and spiritual context for that individual and their family as well being mindful of the possible impacts of racism on the person.

7. Providing Service User Centred Care

Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.

For CDWs this means...

Ensuring the goals of any assistance or intervention are focused on the specific cultural, physical and spiritual needs of BME service users. The CDW will need to assist in the development of goals for assistance offered to BME people that are meaningful to them and their families as well as picking up on patterns of discrimination in service delivery through a 'whole systems' evaluation.

8. Making a Difference

Facilitating access to and delivering the best quality, evidence-based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carers.

For CDWs this means...

Promoting an anti-discriminatory, social model and holistic approach to BME mental health. The CDW will need to facilitate access for BME people to a wide range of culturally appropriate service and non-service options within their communities.

9. Promoting Safety and Positive Risk Taking

Empowering the person to decide the level of risk they are prepared to take with their health and safety. This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for service users, carers, family members, and the wider public.

For CDWs this means...

Helping practitioners engage in positive risk taking and risk management with BME service users and reflect critically upon their judgements about risk. The CDW will need to support BME service users to reduce the risk of self-harm or suicide and manage other risk in their lives in balance with risks to families, carers and others while guarding against stereotyping and stigma often faced by BME people in distress.

10. Personal Development and Learning

Keeping up-to-date with changes in practice and participating in life-long learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

For CDWs this means...

Keeping informed and up-to-date with recent developments in BME mental health issues and changes in policy and legislation. The CDW will need to engage in their own personal development and that of their colleagues with a focus on race and culture issues and develop awareness and expertise as a mental health practitioner dealing with institutional racism.

Appendix F

Allocation of CDWs by Strategic Health Authorities (SHAs)

Mental Health Targets	Community Development Workers by 2006
Strategic Health Authorities	500
Avon, Gloucestershire & Wiltshire	18
Bedfordshire and Hertfordshire	13
Birmingham and the Black Country	28
Cheshire & Merseyside	26
County Durham & Tees Valley	14
Coventry, W, H + W (Birmingham South)	13
Cumbria & Lancashire	20
Dorset & Somerset	9
Essex	13
Greater Manchester	34
Hampshire and Isle of Wight	15
Kent and Medway	13
Leicestershire, Northamptonshire & Rutland	14
Norfolk, Suffolk and Cambridgeshire	17
North & East Yorkshire & Northern Lincolnshire	14
North Central London	16
North East London	20
North West London	23
Northumberland, Tyne and Wear	17
Shropshire and Staffordshire	13
South East London	20
South West London	14
South West Peninsula	13
South Yorkshire	15
Surrey and Sussex	21
Thames Valley	17
Trent	24
West Yorkshire	25
Totals:	500

Appendix G

Role of Race Equality Leads and Contact Details

- **Strategic.** The responsibility for the performance management of the CDW target lies with SHAs therefore, a partnership approach between NIMHE RDC's in its developmental role and SHAs in their monitoring capacity will ensure the most effective outcome. RELs will support Workforce Leads within the SHA to facilitate the development and implementation of the CDW role. One way of doing this would be to form region wide working groups to plan a strategy to implement the CDW's role. Learning from the early implementer sites can feed into this working group.
- **Information and knowledge management.** Communicate information to PCTs. RELs should raise the profile of the CDW role at every opportunity through their existing networks in their regions. Holding localised events, sending information using existing RDC database and communication systems, etc, could do this.
- **Networking and optimising the potential development for CDWs.** Every effort needs be made by PCTs to offer and set up mentoring opportunities for the CDWs. RELs may be able to support this process by negotiating the development of mentoring initiatives with the Workforce Development Confederation. RELs can certainly support the CDWs to develop the capacity for initiating sustainable mentoring relationships, by simply sign posting the CDWs in the right direction and supporting capacity around abuse of role and burn out.
- RELs could develop a framework for a regional CDW network or explore existing BME staff networks that the CDWs can join should they wish to. It would be unrealistic to expect the RELS to run the networks but they could set up the fundamental framework utilising resources such as the Knowledge Community to share information and provide an extra support mechanism for the CDW role.
- The Race Equality Leads will work closely with community development workers to ensure the successful implementation of *Delivering Race Equality A Framework For Action*.

Race Equality Lead Contact Details

NIMHE Region	Appointee	Contact Details
North East/Yorks. & Humberside	Selina Ullah	selina.ullah@bdct.nhs.uk Work: 01274 228370 Mobile: 07957 425451
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APPENDIX H

Delivering Race Equality – Consultation Exercise

How the CDW interim guidance reflects key consultation responses on Community Development Workers within “*Delivering Race Equality, a Framework for Action*”

Consultation response	Reference and evidence within this guidance	Section or page of this guidance
Need for collaborative development of CDW guidance with stakeholders, taking into account BME VCS expertise	<ul style="list-style-type: none"> • Guidance Group composition reflects collaborative approach • Interim guidance issued to allow for learning & modification • Independent evaluation of CDWs planned 	<p>Appendix I</p> <p>Early Implementer Sites</p> <p>[This is to be undertaken]</p>
Clarification needed on CDW status, authority and boundaries to role	<ul style="list-style-type: none"> • Positioning & seniority of CDWs emphasised • Boundaries outlined to avoid CDWs being seen as the solution to all BME issues • Local steering groups and national co ordination of early implementation proposed 	<p>Support & management</p> <p>Who should employ CDWs?</p> <p>Getting started</p>
Clarification needed on accountability & location of CDW posts	<ul style="list-style-type: none"> • Need for integration within existing BME VCS acknowledged. • Non prescriptive guidance allowing local decisions on best location for CDWs to affect change 	<p>Responsibility</p> <p>Getting started</p>
Greater clarity needed about education & training for CDWs	<ul style="list-style-type: none"> • Education, training and Continuing Professional Development (CPD) framework outlined • Acknowledged as an area for further consideration 	<p>Education training and CPD</p>

Consultation response	Reference and evidence within this guidance	Section or page of this guidance
Need for supervision & support, avoiding CDW isolation	<ul style="list-style-type: none"> • Potential for local cohort of CDWs to provide mutual support and learning • Proposal for senior officer support 	Support and management
Clear career structure and progression required	<ul style="list-style-type: none"> • Guidance on potential recruitment strategies and support applicants • Integration of CDW role in forthcoming “A Career Framework for the NHS” 	Career progression Recruitment & retention Terms & conditions
Risk that CDWs will be caught between action required to improve statutory services, and development of community capacity	<ul style="list-style-type: none"> • Overall aims and 4 proposed core roles of CDWs addresses this issue • Guidance also outlines what CDW role is <i>not</i> about • CDWs are an element of a much wider programme of work to improve services for black & minority ethnic groups 	Role Links to the NIMHE programme
Potential relationship to other roles and workers	<ul style="list-style-type: none"> • Emphasis on CDW role as a new role, not a rebadging exercise • Discussion of respective roles & relationships 	Role

Membership of CDW Guidance Group

MEMBERS

Roslyn Hope	Director, National Workforce Programme, NIMHE (Chair)
John Allcock	Associate Director, National Workforce Programme, NIMHE
Shun Au	Chair, Chinese Mental Health Association
Asha Day	Race Equality Lead, NIMHE East Midlands
Peter Ferns	Ferns Associates
Barry Foley	New Ways of Working Programme
Duncan Henderson	Mental Health Lead, Birmingham and Black Country SHA
Poppy Jaman	Race Equality Lead, NIMHE South East
Barbara Kennedy	Milton Keynes Primary Care Trust
Jackie Lynton	Mental Health Lead, Birmingham and Black Country SHA
Mhemooda Malek	National CAMHS Support Service
Kevin Mantle	Mental Health Policy Group, Department of Health
Rachel Munton	Interim Programme Director, NIMHE BME Programme
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265796 *Community Development Workers for Black and Minority Ethnic Communities* can also be made available on request in Braille, on audio cassette tape, on disk and in large print.

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