Towards a Blueprint for Action: Building Capacity in the Black and Minority Ethnic Voluntary and Community Sector Providing Mental Health Services

A study for the African and Caribbean Mental Health Commission

Human Rights for Race Equality
‘There needs to be a change in the mindset of statutory services so that they see the Black and Minority Ethnic voluntary sector as partners that can help them address the problem of over representation of African Caribbean males in the system.’
(Director, Black and Minority Ethnic voluntary mental health service)

‘If money was no object we would work together with other voluntary organisations and run advocacy services in an environment where service users feel safe and there isn’t that oppressive power dynamic.’
(Manager, user-led voluntary mental health service)

‘We have six paid staff, three full time and three part time, and one volunteer, we really need six full time staff but don’t have sufficient funding. There is also the issue of space as we don’t have our own building, rent is expensive.’
(Manager, voluntary sector mental health service)

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Greater London Authority
April 2005

Published by
Greater London Authority
City Hall
The Queen’s Walk
London SE1 2AA
www.london.gov.uk
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foreword by the Mayor
Blueprint for Action makes the case for improving mental health services for London’s black and minority ethnic communities by building the capacity of the black voluntary and community sector to provide services. Its acknowledgement and highlighting of the key role played by black voluntary and community sector organisations in helping to provide respectful, appropriate and accessible services to their communities provides a significant and sound base upon which to develop the sector.

Blueprint for Action identifies the value for money that such organisations represent for those who commission mental health services; and it argues for a strategic framework within which the sector should be resourced to increase its capacity to deliver services that people want to use and which meet their needs.

People from black and minority ethnic communities have long voiced their dissatisfactions with mainstream mental health services. These relate to unequal access to services; fear of services; and frustrations about the kind of treatment they receive.

Black voluntary and community organisations fill a void in helping to change this scenario. I believe the report’s recommendations can have a real impact in enabling them to do an even better job. I have identified mental health as a key policy priority; and have given my support to the African and Caribbean Mental Health Commission to develop work in this area. Blueprint for Action is an important contribution to this process. I urge its use by commissioners and funding agencies in the health service and other sectors.

Ken Livingstone
Mayor of London

executive summary

The African and Caribbean Mental Health Commission (ACMHC) in London commissioned this report in recognition of the need to outline an action plan to engage the BVCS (black voluntary and community sector) more fully in mental health services.

The aims of this report are:

• to examine the nature of service provision by black voluntary sector mental health organisations and assess the capacity building needs of this sector.
to identify the economic and human benefits or value added impact that black and minority ethnic voluntary and community sector organisations have on services to black and minority ethnic communities

• to develop a Blueprint for Action to address the issues which arise in the research.

In addition to a literature review of the most relevant and recent publications and policy context, 30 questionnaires were sent to black-led voluntary sector organisations (25 returns) and 20 questionnaires to statutory bodies or funders (12 returns).

Key findings

• The key message from organisations was for the statutory sector to change its ‘mindset’, and to view the BVCS as equitable and complementary partners who contributed to community engagement and social inclusion and were involved in brokerage and advocacy, policy influence and the provision of culturally sensitive services and early intervention, resulting in reduction of overmedication, admission or re-admission to hospital. This is potentially cost saving (see Tables 4 and 5).

• The importance of black organisations that employ black staff who understand the social, cultural and political experiences of African Caribbean patients who have used mental health services cannot be emphasised enough.

• The lack of long-term funding was often stated as a serious problem affecting the sustainability and growth of BVCS organisations. For many organisations this resulted in an environment of instability for both staff and service users. In most cases projects found it difficult to access funding for their core costs, as opposed to project funding.

• Primary Care Trusts, social services and local authorities were the most common sources of funding for black and minority ethnic mental health voluntary organisations.

• None of the funding providers that participated in this study had ringfenced funding for black and minority ethnic organisations, although some funders were in the process of developing funds targeted at black and minority ethnic groups.

• Organisations responding recognised the need to diversify their funding sources. However, few had the capacity to put much energy into this in practice.
Most organisations found the application process time consuming and few had access to assistance with funding applications.

Organisations that were part of a network were at an advantage when it came to accessing information about funding.

There was widespread acknowledgement that current capacity building provision was inadequate and that more was needed.

Fundraising was the most frequently mentioned of all infrastructure development tools, followed by evaluation tools training, human resources, management tools, business development and payroll administration.

Most organisations had ambitions to expand their services, develop the organisation and provide a more holistic approach to service user need, including through developing research and dissemination of information.

Ownership of property should be a goal of capacity building provision to the BVCS mental health organisations.

All black organisation respondents stated that training was needed in order to deliver the kind of service that they would like to offer over a sustained period of time.

Few among the funders surveyed for this study demonstrated a palpable understanding of the importance of the BVCS or the unique set of challenges facing BVCS groups.

Most respondents were positive about the benefits of partnership working, although small organisations reported that the power dynamic of working in partnership with statutory agencies was challenging as there was often an imbalance.

Organisations spoke of a need for funders to ‘get to know’ the BVCS and individual black organisations.

People with senior management roles and strategic vision in relation to the future operation of their agency, wished to have the opportunity to engage with the organisations as a partner; but as an efficient partner. This implied both an adequately resourced BVCS and a continuity of collaboration.
Summary of recommendations
These recommendations are endorsed by ACMHC and have the support of the Mayor of London. ACMHC hopes to work with a range of stakeholders with a view towards their implementation. Please see section 7 for detail and explanations.

Recommendation 1
A statutory/voluntary sector compact should be developed with explicit recognition of the roles of the voluntary sector and protocols for joint working. This should take account of any work already underway in connection with the development and implementation of the national Compact on Relations between Government and the Voluntary and Community Sector, which was adopted in 1998.

Recommendation 2
A Mental Health Providers Information Exchange (MHPIE) should be established. It is suggested that an initial step will be to create a database and interactive website for providers in London. This will aim to facilitate targeted commissioning, appropriate support for clients and online information exchange between statutory and voluntary sector organisations. The website could also be used to hold e-training packages, policy developments, news items, etc.

Recommendation 3
The ACMHC or another relevant and expert body should work with others to co-ordinate and develop effective approaches to commissioning and to raise commissioners' awareness of the value of the sector. This may involve a brokerage service for commissioning which matched BVCS service providers to services needed by mental health statutory providers/authorities.

Sustainability and funding
Recommendation 4
Discussions should be initiated with NHS commissioners on exactly how much of the Department of Health’s £50 million budget that has been set aside for buying in voluntary sector services will go to the BVCS. We suggest that ACMHC (and others) enter discussions now to ensure an amount is ringfenced for the BVSC which may be based on proportionality to the representation of diverse BME patients in the mental health system.

Recommendation 5
BVCS mental health organisations should be enabled to have increased access to good support. This could include eg; the services of a dedicated fundraiser shared between organisations based in the same area.

Recommendation 6
Funders (statutory and charitable) should consider a work stream that is dedicated to fostering relationships with the black mental health sector.

Recommendation 7
An agreed approach to funding should be developed to increase the sustainability and resourcing of the BVCS. This may take the form of secure medium and long-term funding agreements, which contain a built-in system of review.

**Recommendation 8**
NHS commissioners should target black and minority ethnic voluntary sector services for any outsourced mental health services for BME communities. A particular focus in this regard should be on those organisations who work with patients of African Caribbean origin. They should invest over a sustained period of time in established organisations with the requisite skills, which have identified a gap in service provision.

**Recommendation 9**
All funders (statutory and charitable) should set targets to ensure fair and equitable distribution of funds to black organisations, and information on progress should be made available on an annual basis.

**Infrastructure and capacity building**

**Recommendation 10**
A mental health development centre/unit should be established for the BVCS. This should be linked to existing regional National Institute for Mental Health in England (NIMHE) development centres in order to maximise use of resources. This BVCS development centre/unit would operate as a second-tier agency with strategic objectives linked to the wider objectives of the national NIMHE programme.

**Recommendation 11**
We recommend a further study to look specifically at the mental health needs and service provision for asylum seekers and refugees. We also recommend that statutory services should engage more actively with BME service users generally, in order to capture their views and experiences about which aspects of service delivery are valued. We note the work on the National Black & Minority Ethnic Census currently underway; but would also recommend the use of Race Equality Impact Assessments under Race Relations legislation to develop greater information and choice for BME communities.

**Training (of both the voluntary and statutory sector)**

**Recommendation 12**
It is recommended that approaches to training are identified and made accessible to the BVCS. This may take the form of existing training packages or could include the development of a suite of training packages which could be available online as e-training backed up with face to face training where appropriate. The training programmes offered could be targeted at both the voluntary and statutory sectors.

**Recommendation 13**
Shadowing schemes should be developed which can work both ways – NHS personnel seconded or placed in voluntary sector organisations or voluntary sector personnel placed in statutory services.

**Partnership and dialogue**

**Recommendation 14**
Recognised local BVCS groups should be resourced to facilitate a Critical Engagement Partnership (CEP). These groups should offer guidance, training and support to understand the various arenas of possible engagement (see table 7) and influence.

Recommendation 15
Steps should be taken to develop opportunities for a pan-London approach to promote dialogue and partnerships between those who hold/dispense funds and those who need them. This should encompass a wide range of sectors— including health service commissioners, local government, business, charities and others. Mechanisms for ongoing review should be developed in order to assess the degree of progress towards sustainability of the BVCS.

Recommendation 16
The roles, salary levels and location of CDWs need to be clarified. It would make sense that the community development workers (CDWs) work closely with the centre/unit suggested in recommendation 10, or are even located within the centre, which in turn could be located in the National Institute for Mental Health in England (NIMHE) or the ACMHC1. The black voluntary sector should be involved in the discussions around all of the above.

References
1 If located in ACMHC the emphasis would be firmly on services for African and Caribbean people, whereas within NIMHE this emphasis could be broader across African, Caribbean, Asian, refugee and asylum seeker communities.

1 introduction

1.1 Inequality in mental health services between black people and the majority white population has been the subject of ongoing debate and study for decades. However recent developments and research have resulted in fresh acknowledgements, commitments and impetus for action by mainstream agencies.

1.2 The African and Caribbean Mental Health Commission in London commissioned this report in recognition of the need to outline an action plan to engage the BVCS (black voluntary and community sector) more fully in mental health services.

1.3 The aims of this report are:

• to examine the nature of service provision by black voluntary sector mental health organisations and assess the capacity building needs of this sector
• to identify the economic and human benefits or value added impact that black and minority ethnic voluntary and community sector organisations have on services to black and minority ethnic communities
• to develop a Blueprint for Action to address the issues which arise in the research.

1.4 The research examines a sample of London-based BVCS mental health organisations and looks at their relationship with statutory agencies in relation to services, funding and capacity building needs. It focuses on services for African Caribbean communities but also has relevance to black people in general.

1.5 The black African and Caribbean populations of England and Wales are far more concentrated in London than any other ethnic group. Indeed the second largest non white group in London is black African, closely followed by black Caribbean. Disadvantage and discrimination characterise the experience of black communities in London. People from black and minority ethnic groups suffer poorer health, have reduced life expectancy and have greater problems with access to health care than the majority white population.

1.6 Health Secretary John Reid recently announced proposals for voluntary and community organisations to take over a significant proportion of healthcare and social services previously run by the state. This is a clear indicator of the Government’s recognition that voluntary organisations, with their close community links, are in many instances better placed to provide specialised and culturally appropriate services.

1.7 This study includes an overview of the most relevant reports that have been published over the last ten years on the inequitable treatment of African Caribbeans accessing mental health care services. They demonstrate that the failings of the NHS in these areas are a long way from being addressed and that there needs to be a far greater recognition of the role of the BVCS. The BVCS will struggle to be part of a longer term plan unless their sustainability and developmental needs can be addressed. Relationships and partnerships need to be nurtured in order that strategic and complementary planning and provision can be realised.

References
3 Greater London Authority (2004), Health in London, GLA
4 The Guardian, Thursday November 11, 2004

2 context review

2.1 To inform an action plan and a way forward it is necessary to review the existing context for the provision of mental health services to African Caribbean people in London. This includes:
• racial inequality in mental health services
• policy context: strategies to address black people’s access to mental health services
• the role of black voluntary and community sector mental health organisations
• under investment in the black voluntary mental health sector.

Racial inequality in mental health services

2.2 The recent Social Exclusion Unit report on mental health acknowledged that black people have higher levels of dissatisfaction with statutory mental health services and are twice as likely to disagree with their diagnosis. Black people are also six times more likely to be detained under the Mental Health Act than white people. However, despite over-representation in coercive mental health services, black African Caribbean and South Asian patients are less likely to have their mental health problems detected by a GP. Paradoxically they are more likely to have other problems wrongly attributed to mental health.

2.3 Although African Caribbean people are three to five times more likely to be diagnosed and admitted to hospital for schizophrenia, the prevalence of common mental health problems is fairly similar across different groups.

2.4 A recent survey by the mental health charity ‘Rethink’ on mental health service users with severe mental illness found that:
  • black people were 40 per cent more likely to be turned away than white people when they asked for help
  • Eighty-eight per cent of black respondents have been forcibly restrained under the mental health act as opposed to 43 per cent of white respondents
  • Forty-two per cent of black respondents did not agree with their diagnosis as opposed to 14 per cent of white respondents
  • Forty-four per cent of black respondents were unhappy with the care they received as opposed to 20 per cent of white respondents.

2.5 Despite the disproportionate representation of African Caribbeans within mental health services, progress towards redressing this phenomenon has been slow. The disparities and inequalities between black and minority ethnic groups and the majority white population in the rates of mental ill health, service experience and service outcome have been the focus of concern, debate and much research. However, there is little evidence that such concerns have led to significant progress, either in terms of improvement in health status or a more benign service experience and positive outcome for black and minority ethnic groups.

2.6 The death of Rocky Bennett in 1998 and the resulting government inquiry report published in 2003 confirmed that racism is a prevailing factor in poor service delivery to the African Caribbean community. The Inquiry examined the reasons behind the tragic death of a black patient in a semi secure mental health unit after he was restrained by nurses appointed to take care of him. The Inquiry panel
was unequivocal in its condemnation of the NHS for its failure to protect a patient in its care.

2.7 The Bennett Inquiry called for the acknowledgement of the presence of institutional racism in the mental health service and a commitment to eliminate it. The Inquiry found that the confidence of the black and minority ethnic communities as far as mental health services are concerned has been lost and African Caribbean people have a very real fear of the mental health service10. Rocky Bennett’s death and the subsequent publicity surrounding the publication of the Inquiry report brought to the attention of the wider public the routine inhumane treatment meted out to African Caribbean people detained in mental health institutions. The Bennett Inquiry was not the first to examine the institutionalised nature of racism in relation to the mental health service. Analysis of the history of European psychiatry has led some to conclude that the ideology of racism has become incorporated into the discipline because it was developed at a time when explicitly racist doctrines were widely accepted11.

2.8 The tragic death of Rocky Bennett crystallised the reasons behind the poor engagement of African Caribbeans with mental health services that had been highlighted in previous studies. A report by the Sainsbury Centre for Mental Health examined the impact of racism, stereotyping and cultural ignorance on the delivery of services to black patients. They fear that if they engage with mental health services they will be locked up for a long time, if not for life and treated with medication which may eventually kill them12. Young African Caribbean men with signs of mental illness frequently do not go to their doctor until their illness is so pronounced that their family and friends can no longer cope with them. By this time they tend to be isolated, not only from their own family but also their peer group and their illness becomes more difficult to deal with and treatment in the community is less likely.

2.9 A disproportionate number of people from the black and minority ethnic community are being detained under the provisions of the Mental Health Act 1983. They tend to receive higher doses of anti-psychotic medication than white people with similar health problems. They are generally regarded by mental health staff as more aggressive, more alarming and more dangerous and difficult to treat. Instead of being discharged back into the community they are more likely to remain as long term in-patients13.

Policy context: strategies to address black people’s access to mental health services

2.10 In 1999 the Department of Health’s National Service Framework for Mental Health: Modern Standards and Service Models highlighted the inadequacy of existing services for African Caribbean people. A primary objective of this plan was to address the inequalities in health for all with a special focus on people from black and minority ethnic communities.

2.11 The Department of Health published ‘Inside/Outside’, a detailed review of black people’s experience of mental health services and strategy for change14. The report sets out three key objectives and recommendations for change to improve the overall mental health of black and minority ethnic people living in England:
• to reduce and eliminate ethnic inequalities in mental health service experience and outcome
• to develop the cultural capability of mental health services
• to engage the community and build capacity through community development workers.

2.12 The findings of Inside/Outside were the subject of significant community consultation. Fourteen events took place between December 2002 and March 2003, targeting specific minority ethnic communities in Bradford, Bristol, London, Manchester and Birmingham. The government then developed a draft Race Equality Framework for consultation. ‘Delivering Race Equality’ sets out what should be done by those planning, delivering and monitoring local primary care and mental health services to improve services for users, and their relatives and carers, from black and minority ethnic communities. As well as showing how to meet statutory obligations in relation to equality and human rights, it provides guidance on meeting national targets and other standards and commitments.

2.13 The draft race equality strategy has placed greater emphasis on community engagement. It calls for black and minority ethnic communities, including voluntary and community services, to be more effectively and sustainably involved in planning, designing, commissioning and delivering services. This is not possible without adequate long term funding being made more available and accessible to black and minority ethnic voluntary organisations.

2.14 Published soon after Inside/Outside, the race equality framework has been perceived by mental health professionals as a step backwards focusing the onus for change on the voluntary sector when the problems of misdiagnosis, overmedication, coercive treatment and often violent methods of restraint lie within the statutory sector.

2.15 Many concerns were raised by black and minority ethnic mental health professionals during the consultation sessions that were held in different parts of the country over this framework. They were of the view that placing the onus of responsibility to change the institutional racism within mental health services and the perception of mental health on the black and minority ethnic community was a grave error of judgement that would burden voluntary services even more.

2.16 The Government’s commitment to tackling the long-standing inequalities in mental health provision was restated in the Mental Health and Social Exclusion report in June 2004. The Government is aware that its commitment to addressing these issues cannot be met without the support and full engagement of the voluntary sector:

‘The voluntary and community sector is essential to deliver local services to adults with mental health problems and promote meaningful community engagement. Small local groups are better placed than government to understand and meet local community needs. This is particularly true of people who may be less likely to access statutory services, such as people from ethnic minorities.

The issue of inadequate funding is a long-standing one. Short term funding pressures can lead to effective programmes being closed or left struggling to
survive. The current spending review includes a review of how central and local government can better engage with the voluntary and community sector’16.

The role of black voluntary and community sector mental health organisations

2.17 The statutory sector failings in addressing long-standing and dangerous problems with mental health services for black people has led to black professionals, service users and carers setting up services despite minimal funding to address many of these issues. There is growing acknowledgement of the vital role that local black voluntary and community organisations play in improving mental health services for black people.

2.18 Black and minority ethnic voluntary and community organisations have pioneered a variety of mental health promotion interventions and have the skills to work with local communities to build capacity so they are able to identify and meet their own mental health needs and promote better mental health within the local black and minority ethnic population. But there has been an under investment in this sector over many years; voluntary and community groups require greater access to local decision making, to power and influence and to sustainable core funding17.

2.19 The Bennett Inquiry highlighted a number of progressive black-led projects in both the statutory and voluntary sectors as examples of good practice in this area. These include the Lambo Mental Health Resource Centre (named after the late Nigerian psychiatrist, Professor Lambo), which was set up in the early 1990s in reaction to the large numbers of young black men present in psychiatric wards with nowhere to go once they had been released. The Hope Project in South London through its network of partnerships offers a wide range of culturally appropriate services from assertive outreach and visits to clients in hospitals to housing advice, and a drop-in centre that offers substantial meals to all its clients for just £1.80. The Ebony People’s Association was again set up in response to the first hand experience of the poor treatment and absence of support for black and minority ethnic patients and their families using mental health services. It is the only service of its kind in the country offering support to African Caribbean children who have parents with mental health problems.

2.20 These projects present a snapshot of the variety of BVCS groups serving African Caribbean people in London. They rely on both statutory and charitable funding, which has allowed this report to assess a number of variables based on longevity of the service, types of service provision available, funding and capacity building needs.

2.21 It is now widely acknowledged that voluntary organisations offer added value to planning, design and delivery of public health services, and even more so for black and minority ethnic communities18. The Black Spaces Project19 report looked at black and minority ethnic organisations offering culturally appropriate mental health services to people in the community as an alternative to the mainstream services which lack the ability to respond to the diversity of culture and experience that makes up multicultural Britain today. The Sainsbury Centre for Mental Health is compiling a national directory of mental health services which work with African and Caribbean
communities. This leads on from their report 'Breaking the Circles of Fear', which highlighted that lack of information on such services was a major problem for service users and their carers. The study gives as some of the success criteria for black mental health services (statutory as well as voluntary):

- a strong partnership between statutory, voluntary, private and community organisations
- practical help for voluntary organisations in making applications to funders
- strong links with local service user groups as well as close ties to community-based groups.

**Under investment in the black voluntary mental health sector**

2.22 The BVCS funding study by The 1990 Trust explored the questions of access to funding, issues of discrimination and perceptions of partnership. The report highlighted that funders show preference to particular types of organisations, usually larger organisations seen as having more 'professionalism'. However the difficulties arise because these organisations do not have the same level of resources or capacity as public authorities to keep pace with developments in terminology, constructs, and frameworks that characterise a managerial and mechanistic approach. The very definition of professionalism is problematic.

2.23 One may be professional and be unkind, deliberately narrow in your perspective and routine in your judgements. To be morally active is to live in the moment with your responsibilities and commitment to others. Most BVCS organisations seem to aspire to be morally active organisations. Can 'professionalism' be pragmatically exercised in the context of poor resourcing and capacity?

2.24 Rather the BVCS’s strength lies in its long established tradition of trying to ensure that minority communities can enjoy full citizenship rights and have equal opportunities to participate in British society. Small voluntary organisations, particularly black and minority ethnic groups, find it difficult to access funding, particularly core funding, and the pursuit of grants takes up a disproportionate amount of time. Black and minority ethnic organisations perceive that they are treated unfairly by some funders, through over-scrutiny, stereotyping and inaccurate perceptions of the way in which they work.

2.25 The Sainsbury Centre for Mental Health also identifies funding of the BVCS, in particular user groups, as a material barrier to change over the last decade in how black people perceive and experience mental health services. In particular it identified the problem of short-term funding for black voluntary organisations, and lack of support and information in applying for funding from mainstream sources.

2.26 Recent research into voluntary organisations and groups of service users and survivors of the mental health system has mapped the activities and needs of the sector, including black user-led organisations. It found:
• The service user/survivor movement exists and a large number of people see themselves as belonging to it. It developed rapidly in the 1980s and 1990s, partly because of community care policies and the encouragement of user involvement, and partly because of the work of dedicated individuals.

• Local and national groups and networks provide mutual support, take part in decision making and provide information, education and training, creative activities, campaigning and services.

• Funding for groups and networks is usually insecure and insufficient for their needs.

• The movement is predominantly white and needs to improve its ability to reflect the diversity of race, culture, gender and sexuality among service users/survivors.

• There is a growing black service user/survivor movement, which is striving for resources and recognition.

2.27 The report recommends the development of a national voice for the black service user/survivor movement. This was also recommended by the Breaking the Circles of Fear report24 which made specific recommendations regarding development funding to enable leading black service users/survivors to come together regularly and to start a process of outreach and discussion with black service users/survivors around the country.

2.28 In addition to problems with securing funding, black user-led groups face difficulties in being taken seriously and respected by statutory mental health professionals and funders. Organisations described their experience:

'We are several steps behind the white user movement, so we need to be encouraged, supported... we need to be cherished and valued.'

'I mean they [funders] are actually saying 'you get on with it, we're not going to support you in this and if you fall down, that's your problem, we're not going to pick you up25.'

2.29 Supporting People funding for housing services programme has had a negative impact on black voluntary sector mental health services because the application and monitoring processes greatly disadvantage smaller voluntary organisations. The Supporting People programme has also encouraged mergers, which can eliminate or water down specialist services for black and minority ethnic organisations26. The Bennett Inquiry also called for more secure funding for both national and local black mental health organisations.

2.30 On the following three pages we offer an overview of the most recent and relevant reports and the key points made in each. Later, in section 8 we cross reference these key points to the findings of this study. We do this to illustrate that
there is a growing evidence base, all pointing to the need for sustained investment in the mental health BVCS.

<table>
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<tr>
<th>Report</th>
<th>Key issues raised relating to black voluntary and community sector</th>
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<tr>
<td>A. Breaking the Circles of Fear, Sainsbury Centre for Mental Health, 2002</td>
<td>The report found that community-based psychiatric care is lacking, and recommends that:</td>
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<tr>
<td></td>
<td>1 Primary Care Trusts and Strategic Health Authorities should commission gateway organisations to develop bridge building programmes and advocacy services that ‘re-integrate’ black service users.</td>
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<td>2 -The Department of Health commission a national resource centre to support gateway organisations, which would offer expertise in organisational development, training, and information about funding sources. It would be centrally funded in the medium term but be accountable to a board made up of a majority of representatives from black gateway organisations and the black community.</td>
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<td>3 -The Leadership Centre in the Department of Health’s Modernisation Agency should work with black organisations to develop programmes for black staff in statutory services, and extend training to voluntary sector and service users if possible.</td>
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<td>4 -The Department of Health should identify relevant funding streams for black organisations (such as Section 64 and neighbourhood renewal) and create access for black organisations. Targets should be set to ensure fair access for black organisations, and be embedded within mainstream performance management.</td>
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<td>5 -The Sainsbury Centre for Mental Health should facilitate the development of a national voice for the black user movement.</td>
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<td>B. Black Spaces, Mental Health</td>
<td>The report makes many recommendations regarding the organisational development of black mental health organisations, based on in-depth case studies of seven projects. Its main recommendations for the black mental health sector as a whole are that:</td>
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<td></td>
<td>1 -Support should be provided to enable small black voluntary organisations to develop into medium or larger organisations.</td>
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<td>2 -Students training for mental health work should do placements in black organisations.</td>
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<td>3 -Black and mainstream organisations should engage in collaborative work.</td>
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<td>4 -A team of black user consultants should be developed, including African Caribbean, Asian and African service users. The team would help develop user involvement in black voluntary organisations.</td>
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<td>C. Delivering Race Equality: A Framework for Action, Department of Health, 2003</td>
<td>The framework lists as one of the statutory duties to deliver race equality that ‘those responsible for planning and delivering services need… to involve and build a partnership with black and minority ethnic communities’. (A3, p 28)</td>
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Local council planners and PCT commissioners should (p 29)

- 'support the community engagement process of recruiting and developing black and minority ethnic community development workers.'

- 'Integrate consultation with and representation of black and minority ethnic VCS specialist services, community and faith groups into the strategic planning process and key joint planning groups.'

- 'Put in place robust mechanisms to ensure this representation is underpinned by consultation and engagement with the wider community.'


- The Inquiry profiled several BCVS mental health organisations and noted that though the projects were all successful, they were relatively small and relied on key staff for their survival.

- Professor Appleby had reported to the inquiry that the NHS had a lot to learn from the voluntary sector in providing culturally appropriate services, but that mental health services were ahead of the rest of the NHS on recognising the contribution of the voluntary sector. (p 58)

E. Inside/Outside recommends that:

- 'Statutory mental health providers must work collaboratively with local voluntary sector in developing a variety of service models to meet the needs of ethnic groups'. (p 23)

- 'There is community access to the officers of NHS trusts on a regular basis'. (p 28)

- Training of mental health professionals ‘should include service users and/or voluntary organisations working with black and minority ethnic groups in their programme.’ (p 31)

- Community development goes beyond forging ‘links’ between voluntary and community organisations and statutory agencies.

- Inside/Outside discusses the role of black and minority ethnic community development workers (CDWs), which it sees as involving organisational development, leadership development, identifying local concerns, skill development, supporting local groups to become partners with statutory agencies in developing services, supporting local networks and giving advice on funding sources.

- The report recommends that black and minority ethnic CDWs need to be linked formally to existing organisational structures and that their work needs to be linked with other mental health service development priorities. It stresses that the support, supervision and coordination of community development need work, further discussion and planning, and suggests that the NIMHE Development Centres could support and sustain the initiative.
F. Availability of mental health services in London, GLA, 2003

The report recommends that health commissioners in Primary Care Trusts and Mental Health Trusts would benefit from greater support and development of skills in mental health-primary care services. This skill development needs to be extended to understanding of the black voluntary and community sector and why its work is essential in providing services to African Caribbeans.

G. On Our Own Terms, Sainsbury Centre for Mental Health, 2004

The report found that black people were marginalised within the user/survivor movement and recommended the development of a national voice for the black service user/survivor movement.

H. Mental Health and Social Exclusion, Social Exclusion Unit, 2004

Inequalities in mental health cannot be addressed without the support and full engagement of the voluntary sector:

‘The voluntary and community sector is essential to deliver local services to adults with mental health problems and promote meaningful community engagement. Small local groups are better placed than government to understand and meet local community needs. This is particularly true of people who may be less likely to access statutory services, such as people from ethnic minorities.’

2 -The issue of inadequate funding is a long-standing one. Short-term funding pressures can lead to effective programmes being closed or left struggling to survive. The current spending review includes a review of how central and local government can better engage with the voluntary and community sector.

3 -The government’s action plan, set out in this report, includes: ‘Tackle inequalities in access to services’. However within this action point it makes no specific recommendations regarding black people’s access to mental health services, nor any mention of the voluntary sector’s role in improving access to services. (p 100)

4 -The report recommends the establishment (by the Department of Health) of an Independent Advisory Group (in Autumn 2004) on the action plan, with representation from ‘the full range of relevant sectors’, although it does not specify the voluntary sector or the black community.

5 -The implementation of the mental health and social exclusion report and work to ‘address ethnic minority mental health’ have been set as a funding priorities for the Section 44 Grant, which is the greatest single source of funding from the Department of Health to the voluntary sector.

I. Black Voluntary and Community Sector: Its impact on civic engagement and capacity building.

The black voluntary and community sector’s strength lies in its long established tradition of trying to ensure that minority communities can enjoy full citizenship rights and have equal opportunities to participate in British society.
The black voluntary and community sector (BVCS) is still a relatively new partner with statutory bodies, and the importance of the sector is only just being recognised.

3 - The BVCS finds it difficult to access funding and there is an acute need for more transparency in funding. The report recommended that there needs to be a site or institution providing free or low-cost training and capacity building for the BVCS, including payroll services, templates for minutes, strategic and business plans and other managerial and administrative support.

4 - In addition funders do not appear to understand the BCVS, although some were trying to engage more with the sector. The study recommended that work was done to build the knowledge base of both the BVCS and statutory sector about public bodies’ duties under the Race Relations Amendment Act 2000 and the Human Rights Act 1998.

5 - The research identified issues with power imbalances in partnerships between statutory agencies and black voluntary and community organisations. It recommended that where a statutory body partners a black organisation, the early stages must include agreement on the respective expectations and obligations and on the level of power that each party has.

References
5 Mental Health and Social Exclusion: Social Exclusion Unit Report, Office of the Deputy Prime Minister, June 2004
6 Mental Health and Social Exclusion: Social Exclusion Unit Report, Office of the Deputy Prime Minister, June 2004
8 Mental Health and Social Exclusion, Social Exclusion Unit, Office of the Deputy Prime Minister, 2004
9 Rethink (2003) Our Point of View
10 Independent Inquiry into the death of David Bennett, December 2003 by the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority
17 Users’ voices: the perspective of mental health service users on community and hospital care. Sainsbury Centre for Mental Health, 2001 by D Rose
19 The Mental Health Foundation (2003)
22 Sainsbury Centre for Mental Health (2002) Breaking the Circles of Fear, SCMH
3 research methods

3.1 This section outlines the methods used in this study. In addition to desktop research and literature review, questionnaires were sent out to and interviews conducted with:

- black voluntary and community sector organisations
- key mainstream agencies and funders.

Black voluntary sector interviews

3.2 Questionnaires were sent to a sample (30 sent out with 25 returns) of London black and minority ethnic organisations that provide specialist mental health services to African Caribbeans. The questionnaire was divided into four parts with 37 questions, which covered:

1. organisational details including services offered
2. funding information
3. partnerships and capacity building
4. infrastructure and development needs.

A copy of the questionnaire sent out is in the appendices of this report.

3.3 The questionnaires were e-mailed and posted to organisations and institutions across Greater London. The organisations were identified initially through umbrella and large mental health organisations, internet research and the 1990 Trust networks. Others were then identified through contacts made at the black and minority ethnic mental health organisations.

3.4 The questionnaires were then followed up with phone calls to conduct an interview or arrange a time for an interview. Many of the organisations were difficult to contact and some workers were not able to take time away from service delivery to participate in an interview. In many cases several follow up phone calls were required to make contact with key workers at the organisation. In those cases in which a full interview was not possible, the researcher had a shorter informal discussion with the organisation wherever possible. This discussion informed the study although it did not form a part of the data analysed.

3.5 The interviews were based on the questionnaire but were also flexible to give the interviewees the opportunity to talk about the issues they were most concerned about. Interviewees were either senior staff or trustees.
of the organisation. Each interviewee was informed of the purpose of the study and that what they said would be included in a report about capacity building in the black mental health voluntary sector that would include a Blueprint for Action. They were also informed that the study was being undertaken by the 1990 Trust for the African and Caribbean Mental Health Commission. They were each given the opportunity to keep some or all of their comments anonymous. They were also given the option of filling in the questionnaire and posting it or emailing it back. This option was offered to enable people without time for an interview to participate in the research, and so that people could check the information provided with other staff members if necessary. However only one respondent chose to post the questionnaire back rather than be interviewed. Each interview lasted between 40 minutes and an hour.

**Key mainstream agencies and funders**

3.6 Twenty key stakeholders, including charitable, Department of Health funders and policy making second tier national organisations within Greater London (12 returns) were asked to complete a different questionnaire with four sections covering:

1. organisational detail
2. funding information
3. infrastructure development training
4. funding plans for black and minority ethnic voluntary mental health services.

3.7 The questionnaires were posted and e-mailed to organisations as listed in the appendix. In addition to completing the questionnaires, agencies were also asked to add any other materials they felt would help illuminate or explain their answers.

3.8 All of those that were sent a questionnaire were contacted by phone to arrange a time for interview. Making contact and speaking to the most appropriate person proved to be challenging as most people were very busy and finding time for a face to face interview was difficult. In these cases where a full interview was not possible, the researcher was then passed onto a colleague or conducted a telephone interview.

**Findings from the BVCS groups**

**Profile and typology of BVCS mental health groups**

4.1 From the typology in Table 1, it becomes clear that the respondents in this report provide an eclectic but very similar range of services. None of these organisations provide supported housing. Among the entirety of respondents in Table 1, three main types of services emerge: practical assistance, housing advice and counselling. All but one of the BVCS mental health groups in the table were involved
in practical assistance, such as shopping, cleaning, etc, and providing housing advice. Counselling was also high on the list of services provided, and all but two of the organisations provided this.

4.2 With a few exceptions, most of the organisations began life in the 1990s, a time when government funding in mental health was increased. The Mental Illness Specific Grant was announced in the NHS and Community Care Act 1990 and became operational in April 1991 when £30 million was made available to local authorities for the development of services in the community for people with a severe mental illness. Below a respondent describes a typical beginning of a black voluntary sector mental health service:

‘As a carer I realised there was a gap in services, and was funded for two years without assistance – just council funding for hiring meeting places. We organised a conference and out of that got funding from the Department of Health via social services. Our first major funding was £5,000 from the lottery which was matched by Enfield PCT.’

4.3 Service provision across all the organisations surveyed was marked by the high demand for the services that these organisations offered. Many organisations had weekly client numbers in excess of 100, and all the groups reported at least 20 clients per week. Staff numbers was not a determining factor in the number of clients reached. One of the oldest groups amongst the sample had 35 staff dealing with up to 100 clients per week and offering three types of service; another group with 3 staff handled 76 clients per week offering 14 types of service. Such a differential between staff and client numbers and range of service provision is not necessarily a reflection of organisational efficiency and effectiveness, but rather, it is perhaps indicative of the nature of the service provided and the extent of repeat calls from the same clients.

Black and minority ethnic consortia and umbrella organisations

4.4 Black and minority ethnic respondents fell into two types of organisation: service providers and consortia, the latter of which were concerned primarily with effecting change at a high strategic level. This had a significant effect on the degree of ‘hands on’ assistance available to the grass roots black and minority ethnic service delivery organisations.

4.5 Each of the consortia or umbrella BVCS organisations in Table 2 (below) perceived that it was an organ for positive change, and the importance of this is a given. Being ‘culturally specific’ and promoting healthier black communities were key aims for many consortia, and many believed that the bringing together of BVCS organisations was vital to ensure effective representation at the statutory decision making level.

4.6 Although many of the consortia had services in common, certain key services were rarely available. Given the challenges faced by BVCS organisations, the dearth of capacity building services was particularly conspicuous. In addition, the training of staff and volunteers was obviously not a priority among these consortia because only one provided an employment and training programme.

4.7 Black and minority ethnic voluntary sector organisations, as has been widely reported, require assistance in capacity building and partnership working, and training in fund raising, financial and organisational management, and health promotion. It appears, however, that these basic tools of organisational sustainability
and development are not being provided by either black-led consortia or the statutory sector.

4.8 Influencing strategy ensures that the black voice is heard at the highest decision making levels; however, strategic thinking must also involve black consortia working and thinking in partnership.

4.9 The main role of the BVCS in mental health was seen as the provision of culturally appropriate services that meet a need not currently being met by the statutory sector. In addition there are significant other roles that the voluntary organisations play.

- Economic benefit
  Providing services, especially in prevention and after care, which are of economic benefit to the statutory services.

- Brokerage and advocacy
  The grass-roots credentials and skills are essential as a conduit for a voice for the marginalised to the gate-keepers of power and resources, and as a force of conscience within these communities. The demography, exclusion and experience of very large parts of black Britain continue to offer the prospect of producing angry disaffected populations, particularly of young people. The demand for the capacity building and facilitation of the voice of these communities cannot diminish in the foreseeable future.

- Supporting social engagement
  The mental health BVCS acts as a lifeline to social engagement for those that have been or perceive themselves to be excluded because of their mental health problems. Often the support, empowerment and culturally appropriate services offered by a local community organisation where he or she can identify with the personnel, has more chance of being able to engage with the statutory services.

- Policy influence
  The BVCS is an active and even key player in shaping policies around anti-racism and diversity. The voluntary sector acts as a counter
hegemonic force, which is not necessarily oppositional and more often than not is complementary.

These tasks are essential and difficult; the dual function of speaking for and speaking to these communities places a significant strain upon the organisation and its personnel and must operate in the context of a national Government that palpably needs more connection with the realities and lived experience of black communities in order to provide effective services and challenge institutional racism.

There is a general belief that statutory service providers do not possess a sufficient understanding of the cultural nuances of African Caribbean clients, and that this sometimes resulted in the reliance on drug therapy or early admission as opposed to a more holistic approach to mental health problems. The benefits of culturally sensitive or appropriate services included early intervention, assertive outreach and a potential reduction of admission and re-admission.

4.10 Respondents describe below why these services were set up:

‘Because of own family experience realised other people were going through a lot without support’.

‘Concerned about the over representation of black men in acute psychiatric wards and so sought for ways to treat these patients in a culturally sensitive less severe way’.

‘Gap in statutory services forced us to set up this project.’

‘Former patients from Springfield had nowhere to go and so used to stop by because they had nowhere to go and needed someone to talk to and so we set up a drop in centre at this address with support services that would help them.’

4.11 The importance of client choice was a major theme. Respondents stated that many black clients, either because of previous personal experience, friends’ or family members’ experience, or some other reason, did not like to engage with the statutory sector. Therefore, the BVCS provided an approachable, less threatening alternative to the statutory sector, and ensured that clients who would not otherwise seek help had an avenue to treatment and care.

4.12 BVCS organisations stated that they were more responsive to client needs because they were not encumbered by bureaucracy, compared to the statutory sector, and could therefore act more quickly, even in circumstances that required them to act outside their usual remit.

4.13 Given that the majority of BVCS organisations are staffed by black men and women, there was a belief that staff within this sector are more motivated to help black people (mainly African Caribbean men) than statutory sector staff.

4.14 Mental health problems carry with them a terrible and unjustifiable stigma. Many respondents saw among their responsibilities the raising of public awareness and understanding of the true nature of mental health, and the
destigmatising of mental health illness. This served two purposes: firstly, it encouraged potential clients to seek treatment much earlier, thus reducing the likelihood of coming to the attention of the statutory sector at the point of crisis; secondly, the public would better understand the role of the BVCS and the need to support it.

4.15 However, increased opportunities for training could not be exploited unless the organisation had adequate numbers of staff, without which the demands of work would invariably override the training opportunity, on the basis that the training was always available in the future.

4.16 The importance of black organisations that employ black staff who understand the social and political experiences of African Caribbean patients who have used mental services cannot be over emphasised. Having staff who speak and understand local language is very important, especially if people are in mental distress.

4.17 The report ‘Inside/Outside’ suggests the establishment of a national standard for assessment of black people, with a care plan that would include individual religious, cultural, and spiritual beliefs. The statutory sector is ill equipped to provide approachable and culturally sensitive services that are needed; voluntary groups however already play important roles in health and social care delivery. They support service users, and carers and act as lobbyists, provide a range of health support services and are a conduit for information, particularly on health promotion.

4.18 Local community groups with an interest or role in health and social care are a vital source of expertise in their specialist areas. They also contribute significantly to mainstream service delivery. For example, staff at the Lambo Day Centre in North London are committed to supporting service users and educating them about black history. This restores to their clients a sense of identity so easily destroyed when detained within the mental health system. Through partnership with the local employment agency, career advisors hold surgeries with clients and plan for the future. Looking for and staying in work is one of the most effective ways of keeping well. By offering career advice by partnering with other organisations like the employment services, who can work with clients at the day centre, ensures that clients can get information that will allow them to plan for the future and believe in their ability to grow in a culturally sensitive environment. This sensitive and well-thought out approach to services and care has a value added impact of keeping a client well and focused but, is unfortunately not currently recognised as valuable to NHS commissioners.

**Sustainability and funding**

**Funding**

4.19 Primary Care Trusts (PCTs), social services and local authorities were the three most common sources of funding in the BVCS. Respondents were appreciative of the amounts of funds received and were satisfied with the relationship that they had with funders, although the nature of the relationship differed significantly.
between these three main sources
of funding.

4.20 PCTs as funders produced a mixed reaction. In circumstances where
PCTs acted as partner organisations, respondents reported a distinct power
imbalance, stating that the PCTs were more interested in pushing their own agenda to
the detriment of that of the funded organisation.

4.21 Funding from social services was perceived by respondents to be less
certain than other sources. These funds were generally given on a year by year basis,
which created concerns over sustainability and longevity of the funded organisation.
One respondent stated that their funding situation with their local social services was:
‘…very stressful because we are always on the list of services that might
be cut and so do not know from year to year what will be happening.’

4.22 Local authority funding was perceived to contain conditions. It was
believed that local authorities only funded local groups as a tick box exercise to
demonstrate that they were working in partnership with the community via the
voluntary and community sector, whereas in reality the partnership was limited to one
of donor and receiver.

4.23 Other sources of funding included the London Development Agency, the
Lottery Fund (now known as the Big Lottery) and charity shops. One enterprising
group, in the spirit of social enterprise, had recently begun to organise events as a
way of raising funds, and they found the exercise to be profitable. Another respondent
received in-kind donations in the form of TV licenses and furniture from a local charity.

4.24 None of the respondents reported receiving funds from charitable trusts.
Historically, charitable trusts have given not only a fairly low percentage of funding to
the black voluntary sector, but also relatively small amounts (Chouhan and Lusane,
2004).

4.25 Organisations recognised the importance of diversifying their funding
streams beyond one or two funders, as the uncertainty this instilled had
a damaging effect on organisation’s confidence in its own sustainability. However,
implementing this was problematic due to the lack of resources.

4.26 The actual levels of funding received by organisations varied
considerably, ranging from £500,000 to £15,000, and was usually proportionate to the
number of staff, which ranged from 28 to one full time member of staff. Unsurprisingly,
almost all the respondents complained that current levels of funding were insufficient
adequately to meet the needs of their clients, although none of the respondents
identified what levels of funding constituted adequate funding. In most cases funding
was mainly for projects, rather than for core costs.

‘We have six paid staff, three full time and three part time, and one
volunteer, we really need six full time staff but don’t have sufficient funding. There is
also the issue of space as we don’t have our own building, rent is expensive.’

Access to funding

4.27 The degree of access to funding information varied among the
respondents, although organisations funded by PCTs generally reported good access
to funding information; however, it was unclear whether the information was
intrinsically good or whether the respondent was simply happy to have successfully
navigated the funding application process. Approximately a third of the respondents
used the Internet as their sole source of funding information, and as a tactic, this tended to produce variable results. Respondents said:

‘...accessing appropriate funding that does not take up all your time to apply for and then runs out as soon as you get it.’

‘It takes time to learn how to establish exactly what funders are looking for. It’s about learning how to fill in the forms. Once you have learned how to fill in the application form and give the funders the information they are looking for then the process is fine, but for those who aren’t aware of all the requirements needed it can be quite difficult.’

4.28 No pattern emerged to suggest that any particular funding body provided good funding information. Local authorities provided information on their own funding opportunities. Organisations belonging to a network or forum were clearly at an advantage when it came to accessing funding information when compared to those organisations who were not part of a long-standing, equitable partnership. Membership of a network provided the best opportunity to share information and best practice generally, and this advantage was clearly demonstrated in terms of funding information. One organisation, whose funding relied entirely upon social services, reported that they do not actually look for funding on the basis that social services have funded the organisation annually for a number of consecutive years.

The application process

4.29 The majority of respondents found the application process time consuming, and this was unconnected to the source of the funds. Assistance was not often available; however, it was not clear whether this was because none was offered, or help was requested but not forthcoming. The European Social Fund application was mentioned by one organisation as being particularly difficult and complicated to complete. It was felt that funders did not appreciate that voluntary groups, despite their limited resources, still had to ensure that they were delivering services, and that consequently, completing application forms would invariably demand, as one respondent put it, ‘a lot of late nights’.

‘Difficulty is that we don’t have a dedicated fund raiser so a job that is time consuming and takes a lot of energy falls on the manager which means we are over stretched.’

‘Too time consuming; there is a lot of funding about but it’s all really piecemeal and it takes a lot of time to fill in the forms. Most of my time is spent form filling.’

4.30 Some respondents believed that the success or otherwise of a funding application was determined by meeting the funders needs, rather than demonstrating meeting client demand. It was perceived that using the right language on application forms was the secret to success. Among a minority, it was thought that ‘it’s who you know that matters’, although this was expressed in more discreet terms by one respondent who stated that developing relationships with funders was a key factor to successful fund raising.

4.31 A service provider comments on racism in the funding process:

‘I have applied to Enfield PCT for funding so many times but I always get turned down, even though I have been running my service for seven years. They know
my services are over subscribed, I have more clients than many of the white services around here and yet they have more funding than me.’

**Sustaining the BVCS in mental health care**

4.32 Unsurprisingly, adequate funding was identified as the best way to help sustain the BVCS. The issue was not so much the reallocation of resources from one sector to the next, but rather the need for levels of funding that would enable the voluntary sector to continue to provide services, build capacity, and allow room for proper forward planning. In addition, long-term funding was seen as the key to sustainability. Short-term funding meant that organisations could not effectively plan for the future. Long-term funding meant that better staff could be recruited and retained, and that proper business development planning could take place.

‘Unstable funding means that it’s not possible to forward plan or develop services because we don’t know if we will have the money to sustain the services.’

4.33 Linked to this was the need for funders to understand the BVCS better, but also to get to know individual black organisations, to see how they worked and to get an appreciation of the demands and constraints placed upon them. It was important that funders understood that black organisations provided real services, that they were complementary to the statutory sector, and that they were vital to the continued treatment of black mental health clients.

4.34 The key message was for the statutory sector to effect a change in mindset, and to view the BVCS as equitable partners who contribute to the development of policy and practice, community engagement and social inclusion, and not simply as service deliverers.

4.35 The process of completing applications for funding, as mentioned earlier in this report, is an ongoing concern for the voluntary sector generally, and is a particular problem for the BVCS who often have to overcome stereotyping by funders. Therefore, respondents believed that help with completing funding applications would increase their chances of successful fund raising. When asked about a long-term plan for black voluntary sector mental health services, one manager said the sector needs:

‘…appropriate long term funding that does not have a time limit on it. Although we are funded by the PCT we are at the mercy of funders and really don’t know what will be happening here in the future. In the time we’ve been open we have gone from six to four paid staff. A commitment to the funding and support from the powers that provide it. Funders need to get a better sense of the climate as things change, the type of service that we have offered over the last twelve years has changed because referrals change. We now have asylum seekers and dual diagnosis referrals and we may need to bring in specialist workers issues with different requirements. Things are less stable in the voluntary sector, there needs to be stability.’

4.36 A well trained, well-equipped workforce was another key component of sustainability, which could only be achieved through a commitment to individual and organisational learning and development. A range of skills and knowledge were
identified as good ways of building capacity, including training in fundraising, understanding mental health legislation and best practice, and business planning.

4.37 A key expression of self determination is the ownership of property. Appropriate premises and the ownership thereof was seen as the foundation for the sustainability of the BVCS in mental health care.

4.38 A funding strategy for the sector is required, based on the premise that long-term core funding of the BVCS by the statutory sector should be de rigueur. Five years was suggested as a minimum, although three years was also acceptable. This would alleviate the usual pressures of fund raising and provide the space needed for organisations to consider a strategic approach to their work.

4.39 Facilitated networking among the BVCS and the statutory sector would encourage the exchange of information, best practice and a mutual understanding. Good management, which included strategic planning, good financial management and fund raising skills, allied with business coaching, would provide managers within the BVCS with the skills necessary to produce and implement strategic development plans, initiate and maintain strategic partnerships and recruit, develop and retain high quality staff.

A service provider comments on sustainability and core funding

‘The Hope Project has been run on a shoestring for almost eight years. Wandsworth Council who fund the project know that this service is needed but I have been running this project on next to nothing for longer than I can remember’.

Michael Walker, Manager of The Hope Project in South London.

Infrastructure development and capacity building

Infrastructure development needs

4.40 Most respondents agreed that infrastructure development meant good systems in organisational and financial management, business planning, continuous staff training, the combination of which would allow the organisation to function and grow. From a range of development needs in the questionnaire, most respondents selected at least two options, the most frequently selected being fund raising.

fig 1 Infrastructure development needs

source 1990 Trust analytical statistical study based on field research, 2004.

4.41 Most respondents were aware of current capacity building provision, and made use of that provision. This included bookkeeping and fund raising assistance. Organisations offering capacity building provision included CEMVO (Council for Ethnic Minority Voluntary Sector Organisations), Southwark social services, South London and Maudsley Mental Health Trust and Brent Black African and Caribbean Mental Health Consortium. Two respondents stated that they had access to a dedicated business development manager.

4.42 Some respondents felt that capacity building provision was difficult to access, mainly because the information they required was not available from a ‘one
stop shop’, and that consequently to find the information that best served their capacity building needs included an element of time consuming and occasionally unproductive information hunting.

4.43 There was widespread acknowledgement that current capacity building provision was inadequate and that more was needed. Once again, fund raising was top of the list, as well as business development, on-going mental health legislation training and general management support.

4.44 Some respondents expressed a desire to branch out into research and a wider information dissemination programme (eg, via their own website) as a complement to the outreach and support services they currently provide. The responses to this question demonstrated that most organisations had ambitions to expand their services, develop the organisation and provide a more holistic approach to client need.

4.45 Finally, a larger BVCS at the expense of the statutory sector could be better for clients in the short term, but there would be more staff within the mental health service sector with job insecurity, an unredeeming fact of life in the voluntary sector.

Skills and training needed

4.46 Almost all the respondents stated that they were not adequately equipped to provide the services they would like to, and the main concerns were around funding. Lack of funding meant that staff numbers were insufficient, and that existing staff were often under trained to provide a first class level of service based on an understanding of current mental health legislation, policy and current practice.

4.47 All the respondents stated that training was needed in order to deliver the kind of service that they would like over a sustained period of time. A lack of knowledge of current mental health legislation and policy was seen as a significant barrier to the provision of services over the long term. When asked what capacity building provisions they needed, one respondent said:

‘Ongoing training on mental health legislation and local policies, we do a lot of our work in the dark because there is a lack of ongoing policy and procedural training that is needed to keep up with these things.’

4.48 Respondents also identified training in management, fund raising, evaluation, social work and counselling as essential components of the sustained delivery of services.

‘I’ve only had ad hoc one and two day training courses that have not really updated my skills. We need training to meet skills gaps so that we can offer and grow an effective service. I manage accounts for Hope but have never had appropriate training in this area.’

Partnership and dialogue with the statutory sector

4.49 Most of the respondents have had experience of working in partnerships with both voluntary and statutory sector organisations, and many were currently working within such partnerships.

4.50 Only one of the respondents was not currently working in partnership; however, they appeared to have a close relationship with their social services funder.
Most respondents reported that their partnership working had proved to be successful, and that there were many benefits to be accrued, such as joint learning. Some explained that partnerships provided training opportunities for their staff and volunteers; others stated that the real beneficiaries were the clients because it plugged the gaps in services. The exchange of views and good practice and a supportive environment were among the positive experiences of effective partnership working. Smaller organisations reported that the power dynamic, especially with the statutory sector, was challenging, and that there was often an imbalance.

‘The power dynamic makes working difficult and they only want to pursue their agenda and priorities. They have no interest in the real needs and requirements of black organisations and service users.’

4.51 However, despite the range of experiences, all respondents stated that they would willingly enter into new partnerships, but with the caveat that the power imbalance they sometimes experienced needed to be satisfactorily addressed. One respondent stated that their social services had established a Pathway to Partnership, which worked well. Further investigation, which is outside the remit of this report, is required to test this. If the case is proved, it could be used as a best practice model meriting replication.

**Reasons for partnership working**

4.52 There were three main reasons given by respondents to explain their motivation behind working in partnership: necessity, complementary working and sharing resources. Overarching all these was the desire to best serve the interests of the client at all times. The organisations that reported the most significant problems of capacity stated that their partnership working was driven by necessity. Lack of staff and expertise meant that partnership working was seen as a real opportunity to increase the impact of their organisation by utilising the skills of staff from other organisations. One respondent stated that:

‘there is a massive agenda and no one agency can deal with all of it’.

4.53 Some organisations stated that by working with other organisations that provided complementary services, they were best able to meet the needs of their clients, and indeed provide additional services, an example of the whole being greater than the sum of the parts.

4.54 Sharing resources with larger organisations was a key motivator. Approximately a quarter of respondents stated that they shared premises with organisations with whom they worked in partnership, and that sometimes the partnership working was as a result of the rapport built up with the ‘incubating’ organisation.

4.55 Some partnership working was a condition of funding, and this generated some disquiet among organisations because alliances of necessity often came with a power imbalance, which made it difficult for very small, disempowered organisations to pursue their own agenda.
Most respondents, however, expressed their organisations’ commitment to partnership working, regardless of the actual reasons that first led them into such partnerships.

The response received from all black and minority ethnic community organisations that were contacted was that the mindset of funders and the commissioning managers working in statutory services needs to change. Commissioners need to see the black and minority ethnic voluntary sector as partners that can help them address the problem of over representation of African Caribbean males in the system. Statutory services see the growing number of black patients as a financial burden costing them money.

Statutory services focus on the cost that psychiatric in-patient care has on PCT and Mental Health Care Trusts’ budgets. They want to know how the black and minority ethnic voluntary sector can save them money by helping to reduce the number of people who need to stay in the services. Black and minority ethnic voluntary services are acutely aware however that African Caribbeans, like any patients, need access to the full spectrum of care, not just compulsion and medication, to recover.

The problem is that statutory services don’t see that the black voluntary sector can deliver this; the irony is many black and minority ethnic services are doing this but do not articulate their aims and achievements in the language commissioners use to measure the impact of their work. This had led to calls for the black and minority ethnic communities to examine how they develop their own evidence base.

Too often NHS commissioners and NHS Trusts see the voluntary sector as amateur. But many voluntary organisations use fully paid staff. There is a misunderstanding on the part of funders about the value added impact of community voluntary services that will in the long term save money. What is needed are clear lines of accountability and joint clinical governance arrangements. Voluntary organisations should be considered fit players on a level playing field27. See Tables 4 and 5.

**Sectoral analysis of the cost of inpatient and outpatient psychiatric care**

There is growing body of evidence to suggest that culturally appropriate services, assertive outreach and crisis resolution services are effective interventions when dealing with mental health patients. The tables below compare expenditure between voluntary services offering culturally appropriate services and statutory services. Voluntary organisations receive a fraction of the financial support given to statutory services. The wide variations in spending could mean one of two things: either there is a need for greater awareness and acknowledgement of the effectiveness and cost effectiveness of BME led mental health services, such as assertive outreach; or the way in which mental health services are funded and facilitated needs to be more convergent with the Delivering race equality in mental health care action plan report (DH January 2005).
Table 4  Cost of outpatient psychiatric care

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Description of service</th>
<th>Costs</th>
<th>Per</th>
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<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service per day annum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black led non profit assertive outreach services</td>
<td>Provides culturally sensitive services to clients in the community, with staff recruited from the communities they serve</td>
<td>£25</td>
<td>£9,125</td>
</tr>
<tr>
<td>BME voluntary/ non profit day care</td>
<td>Service run by local services like The Harmony Project, Lambo or The Hope Project. They provide culturally appropriate black led services including family befriending, advocacy and counselling</td>
<td>£28</td>
<td>£10,220</td>
</tr>
<tr>
<td>Social services day care</td>
<td>Service run by social services to provide care and support to people with mental health service needs in the community during the day.</td>
<td>£36</td>
<td>13,140</td>
</tr>
<tr>
<td>NHS Trust day care</td>
<td>Service run by NHS to provide care and support to people with mental health service needs in the community during the day.</td>
<td>£55</td>
<td>£20,075</td>
</tr>
</tbody>
</table>


Table 5  Cost of inpatient psychiatric care

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Description of service</th>
<th>Costs</th>
<th>Per</th>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Service per day annum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment centre providing care for former long stay patients</td>
<td>Transition from a psychiatric unit to more independent living. Costs for this service include social work services, accommodation costs and health specialists.</td>
<td>£235</td>
<td>£85,775</td>
</tr>
<tr>
<td>Care home for former long stay patients</td>
<td>This service is primarily for long term patients in need of sheltered accommodation and supported living accommodation. Places on such schemes are offered to former long stay patients who intend to move onto a less supported environment in time.</td>
<td>£180</td>
<td>£65,700</td>
</tr>
<tr>
<td>Acute NHS hospital patients who become acutely ill</td>
<td>Designed for short stay for a short space and need intensive care. Average length of stay is one month however some patients stay for much longer periods of time.</td>
<td>£172</td>
<td>£62,780</td>
</tr>
<tr>
<td>Long stay NHS hospital</td>
<td>Inpatient psychiatric wards usually become home to patients once they have been admitted. As soon as a patient gives up residence in their private accommodation a full package of costs is set up including personal expenditure.</td>
<td>£146</td>
<td>£53,290</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Description of service</th>
<th>Costs</th>
<th>Per</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Service per day annum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and social services independent living</td>
<td>Living in the community with a Care Programme Approach care plan detailing support services and support workers</td>
<td>£46</td>
<td>£16,790</td>
</tr>
<tr>
<td>with psychiatric provision package</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NHS psychiatric intensive care unit (PICU)</strong></td>
<td>This acute unit is usually situated within a psychiatric hospital. People are admitted to these units when they are most ill and it is staffed with a higher ratio of staff to patients to deal with the demand.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Forensic unit</strong></td>
<td>Secure establishment where patients suffering from a mental illness who may have committed an offence, or who may have the potential to commit an offence or harm themselves as a result of their illness, can be treated. The units have high levels of staff and security and are intended to give patients high levels of treatment and supervision in a purpose built, secure environment. They also serve to allay fears about improve public safety.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| £435 | £5,354 |


5.1 Both charitable and statutory funding commissioners were interviewed for this report and indicated that funding and grants ranged from as little as £1,000 for a small one-off project to £300,000 over a three year period. All charitable funders that responded to the questionnaire indicated that the overriding determinant for granting funding was to help break cycles of disadvantage and dependency. Health and mental health as a funding priority came high on the list of all funders; however no funds have been ringfenced for black and minority ethnic mental health.

5.2 Socially progressive funders like the Tudor Trust and The King’s Fund primarily fund voluntary organisations working towards reducing social exclusion, poverty and disadvantage across London while promoting equality and reducing discrimination. The Big Lottery Fund’s public consultation completed in January 2005 targeted previously underfunded sectors, including black and minority ethnic mental health services, in order to establish a strategy on how this issue can best be addressed. The King’s Fund also is preparing to undertake an initiative targeted at building the capacity of smaller mental health organisations with a strong emphasis on the black and minority ethnic voluntary sector, which is due to start in 2005.

5.3 All the statutory services contacted have responsibility for managing and commissioning a whole range of mental health care services. Ealing PCT is one of the largest trusts in the country, leading on the provision of psychiatric care in London. Ealing PCT has responsibility for the region’s forensic services and high security psychiatric units including Broadmoor, while at the same time funding more progressive and culturally appropriate mental health care initiatives like the user led

References

### 5 Findings from mainstream bodies

**Profile of capacity building and funding providers**

5.1 Both charitable and statutory funding commissioners were interviewed for this report and indicated that funding and grants ranged from as little as £1,000 for a small one-off project to £300,000 over a three year period. All charitable funders that responded to the questionnaire indicated that the overriding determinant for granting funding was to help break cycles of disadvantage and dependency. Health and mental health as a funding priority came high on the list of all funders; however no funds have been ringfenced for black and minority ethnic mental health.

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Forward Project and a Somali mental health advocacy service. Indeed Ealing PCT was a major contributor of the funding to the local branch of the national mental health charity ‘Mind’, which amounted to a quarter of a million pounds over a three-year period. Funding for black and minority ethnic mental health voluntary organisations has not been ringfenced by any of the organisations interviewed. They all stated that the aims of their organisations were to invest in projects that would improve the health and welfare including mental health of the people living in London.

**Supporting BVCS mental health groups**

5.4 One funder had a programme for mental health organisations generally, but not specifically for black and minority ethnic mental health service groups. In addition, many funders targeted disadvantaged and marginalised communities, categories within which black and minority ethnic mental health service groups’ clients would fall, which they believed, justified having no specialist black and minority ethnic programme:

‘[We] do not focus on the black and minority ethnic community – we just take what are considered the most innovative projects and fund them’.

5.5 There was a positive response to the question about funding to black and minority ethnic groups. Most funders had funded black and minority ethnic groups, and one funder reported that ten per cent of mental health projects are black and minority ethnic led; however, given some of the responses from funders, it is not clear whether such facts are merely anecdotal.

5.6 On the subject of the perceived needs of black and minority ethnic mental health service groups, some funders demonstrated some understanding of the difficulties faced by black and minority ethnic groups and indeed echoed some of the thoughts of the black and minority ethnic groups themselves. One funder stated:

‘[Black and minority ethnic groups need] less piece meal funding, better business development, evaluation training and management skills. Appropriate support through the funding maze system is discriminatory at the moment because black and minority ethnic voluntary organisations do not speak the language of Commissioners and do not have the time or the appropriate skills to effectively access adequate funding’.

5.7 Many key stakeholders stated that they intended to work with BVCS groups in the future, although on closer scrutiny, these plans were not targeted. The prospect for future working was not because the BVCS was being targeted, but was as a result of BVCS groups chasing certain types of funding programmes or simply because BVCS groups were so prevalent in London that there was an inevitability of key stakeholders working with the BVCS.

5.8 A few stakeholders, however, stated that they had specific plans to extend their reach within black and minority ethnic areas, to address the needs of smaller voluntary groups, and to make funding more accessible to BVCS groups. These stakeholders recognised the role of the BVCS in delivering services and its ability to reach the black and minority ethnic communities.

‘We recognise the importance of the black and minority ethnic voluntary sector in providing services to, and advocating for, a marginalised section of society.’
Therefore we hope to continue and develop the work we have done in making our funding more accessible to these organisations.

**Current funding programmes**

5.9 Funding organisations who responded to the questionnaire all provided for core and project funding, which comprised revenue and capital amounts. Each funder had its own unique set of funding criteria that applicants for funds had to match in order to have a chance of success. However, tackling disadvantage was a common criterion.

5.10 Specific groups in which applicants had to demonstrate an interest included disabled children, black and minority ethnic communities, refugees and asylum seekers; areas of interest included health, mental health, drug abuse and learning.

5.11 Start up organisations were not generally catered for by the funders questioned. One reason given for this by one of the funders was that start ups were too big a risk and that the funding organisations were not geared up effectively to manage higher risk groups. Most funders preferred to make grants to organisations with a track record of quality service delivery, and a good reputation within the local community. Exceptionally, funding for start ups was possible, but the best route to this was either through second tier organisations that helped emerging groups, or as a project within a long standing organisation.

5.12 Funding for start up groups required development funding, which none of the responding stakeholders provided. Funding organisations generally concentrated their efforts on well established groups, each with a verifiable track record of delivering services and receiving and accounting for grants.

5.13 To obtain funding, BVCS groups had to make themselves known to the funders. None of the funders had a proactive programme of seeking out the best community organisations with whom to conduct business, and there was no suggestion among any of the stakeholders that the responsibility should be shifted from the potential grant holder to the potential grant giver.

**Levels of funding**

5.14 The maximum grant among the responding organisations is £500,000 per annum over four years, although this was an exceptional award. In addition, there was no suggestion by the particular funding organisation that this was the beginning of a trend.

5.15 Most funding streams were for three-year periods, although two and one-year funding was available. Large grants ranged from £60,000 to £300,000; smaller grants ranged from £5,000 to £50,000 or £60,000.

5.16 The majority of funders did not pursue a policy of renewed funding, which means that grant holders were either not permitted or not encouraged to return to the same funder for new funds. The exception to this was local authority funders, who usually funded on a renewable year to year basis.
5.17 Short term funding of less than one year was not usually available; however, one organisation did have a six-month grants programme for amounts of £1,000 to £2,000.

**Funding assistance**

5.18 There was evidence that funders provided assistance for groups applying for funds. This assistance took a variety of forms, and included ‘how to apply’ sessions conducted by regional outreach staff, face to face support at the offices of the applying group and telephone advice.

5.19 Some funders would only discuss the funding idea and provide guidance, rather than provide advice on the application process. This was determined by the size and resources of the funding organisation. The smaller funders stated they did not possess the resources to provide help with the application process, although if they were able to, they would do so.

5.20 Information about funding is publicised using a variety of media. Most respondents had their own websites and made use of them by providing extensive information about their funding programmes, including how to apply, funding amounts and funding criteria. The larger organisations provided online applications. Other media used included websites of other organisations, local publications, networks, conferences and roadshows, and black and minority ethnic group networks.

5.21 The process of monitoring and evaluating projects was routine among all the grant giving respondents. Grant holders were provided with a project evaluation template, comprising key questions related to inputs, outputs, outcomes and expenditure incurred, and were required to complete annual and quarterly self evaluation forms. In addition, all grant holders were subject to at least one monitoring visit per year from the grant giver.

5.22 In all cases, evaluation of grants were mainly outcome led, and the annual reporting requirement was against outputs, budgets and finances. Outcomes were entirely focussed on the project, and did not seek to identify potential organisational improvement or growth, such as raised skills set, establishing new partnerships, or more effective contributions to group networks.

**Capacity building provision**

5.23 Few funders provide capacity building support, but many stated that they provide grants to organisations that do. One organisation provides generic courses in business planning and how to run a management committee; otherwise, support was sometimes provided in developing a business plan insofar as it related to the funds given by the funder.

5.24 There was a limited system for feedback from grant holders about the monitoring process. The best example was from a national funder, who stated: ‘Most grant-holders develop a relationship with grants’ staff in their regional office, and can offer comments on the process at any time.’

5.25 Working with black and minority ethnic groups was not always seen as a priority issue. One stakeholder, however, demonstrated an understanding of the
capacity needs of black and minority ethnic groups and the value of facilitating networking:

‘We have a membership list that enables black and minority ethnic organisations to network, useful as small scale organisations don't have time to address issues like those in the draft Mental Health bill but through this network their views can be picked up by other organisations like Diverse Minds and fed into our Government response.’

In terms of ease accessing information, staffing issues made this problematic:

‘if you don't have the time because you are overworked there is no way you can access information about this even when it is free.’

Few among the stakeholder groups demonstrated a palpable understanding of the importance of the BVCS or the unique set of challenges facing BVCS groups. As one stakeholder stated:

‘There has to be care taken that the black and minority ethnic sector is not burdened with the responsibility of addressing the failures within the NHS. Black and minority ethnic voluntary organisations tend to arise due to deficiency in the system, they should not be seen as a solution to the problem of inequalities in mental health care. They are by nature small scale and local with good community knowledge, which is invaluable but by no means replaces the statutory services which we have paid for.’

6 case studies

The Mellow Campaign – London E3

History

This initiative was set up in 2000 to reduce the over representation of young African Caribbean men in mental health services and to develop a response to mental health among this group.

Service Provision

Mellowship – a creative expression programme using the arts to explore stigma and recovery issues facing young African Caribbean men.

Employment – in partnership with Sainsbury Centre’s Employment Support Unit, Mellow provides specialist employment to Mellow’s target group.

Community engagement – two initiatives have come out of this area, in partnership with the Harmony Project, Mellow have set up The Unbreakable Project for young Somali men in Tower Hamlets and The Newham Community Engagement Programme.

The Mellow Campaign will be developing a mentoring project with the charity Rethink and offers training and information to professionals across all sectors.

Funding requirements

Funding needs to be long term to allow programmes to achieve their full potential.


**Capacity building requirements**

- Fundraising, evaluation tools and training; business development and legal business advice.

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**Lambo Day Centre – London N19**

**History**

This centre was set up in 1992 in response to the need for people leaving mental health services to have the support of services offered by a culturally appropriate service set up to reflect the people it was set up to serve.

**Service provision**

- Welfare rights advice – professionals are brought into the centre from the Citizens Advice Bureau to assist with any issues a client may have in a safe and familiar environment.
- Employment and careers advice – a careers advisor again comes into the centre to advise clients on what options were available and offer assistance in what is often a long and hard journey back to work.
- One to one counselling – staff from Kacsa (drug and alcohol counselling) visit the centre offering advice to clients on the danger of drug use, this is a very pertinent service as many African Caribbeans are labelled as having dual diagnosis through occasional drug abuse.

**Funding requirements**

Initially funded under a mental illness specific grant this project is now supported by social services which disqualifies them for applying for funding despite the fact that there is an increase in demand; paid staff have been cut from six to four people since the service opened.

‘Ideally we need a commitment from our funders to support our services long term. There are more asylum seekers being referred to our services and appropriate training is needed to deal with these client groups as their needs are distinctly different from other black and minority ethnic clients that use our services.’

**Capacity building requirements**

- comprehensive training on current policy and legislation surrounding mental health
- appropriately trained staff or resources to train them, people are often willing but not able, training can fill that gap.


7 Conclusions and recommendations for Blueprint for Action

Introduction
The Blueprint for Action as commissioned by the ACMHC takes the form of key recommendations outlined below. These are based on the evidence from the findings of this research and from previous reports as detailed in section 8, table 6.

This report is endorsed by ACMHC and has the support of the Mayor of London. The aim is to move towards its implementation through the development of a range of approaches.

The recommendations are, in our view, the steps that need to be taken to strengthen and sustain the mental health black voluntary and community sector and enable improved involvement of black people in the delivery of mental health services (both statutory and voluntary). John Reid has clearly recognised the important and complementary role of the voluntary sector provision; however this is dependent on acting on this commitment and the appropriate investment of resources. If the statutory and voluntary sector are to work in partnership to tackle the institutional racism in mental health services and provide culturally appropriate services it is imperative to provide a strategic and practical framework.

The conclusions and recommendations are grouped as follows:
- valuing and recognising the black voluntary and community sector as commissioners and providers
- sustainability and funding
- infrastructure and capacity building
- training (of both the voluntary and statutory sector)
- partnership and dialogue.

7.1 Valuing and recognising the BVCS role in service provision

This study reinforced the findings of previous studies that black and minority ethnic community and voluntary groups play an irreplaceable role in health and social care delivery. They offer culturally appropriate and sensitive support to African and Caribbean patients using mental health services as well as actively work to prevent admissions and readmission into the system.

The findings in the Bennett Inquiry reveal it is more expensive to treat patients in hospital. Early treatment, mainly in the community, gives good value for money. The work of black and minority ethnic voluntary organisations is not only economically sound, but potentially saves lives. Local community groups with an interest or role in health and social care are a vital source of expertise in their specialist area. As such, these services contribute significantly to mainstream health service delivery.
The first stage towards action is to recognise the roles of the BVSC in mental health and in particular the tensions and difficulties as explained in 4.9 above. These can be summarised as follows:

- culturally appropriate service delivery reaching people statutory services cannot
- providing expertise especially in prevention and after care such as early diagnosis and counselling, which is of economic benefit to the statutory services
- brokerage and advocacy
- social engagement
- policy influence – including challenging institutional racism.

‘These tasks are essential and difficult; the dual function of speaking for and speaking to these communities places a significant strain upon the organisation and its personnel and must operate in the context of a national Government that palpably needs more connection with the realities and lived experience of black communities in order to provide effective services and challenge institutional racism’. (From 4.9 above)

Since a significant part of the BVCS work involves confronting statutory services with their continuing failure adequately to implement extant policy, this requires some sophistication. This again points to capacity building, and developing engagement infrastructures both in the voluntary and statutory sector (please see below under 7.5 Partnership and dialogue).

The statutory and voluntary sector need to work in partnership to develop skills and understanding, which will enable them to work together effectively. If funders and the black and minority ethnic voluntary sector can agree on the shared ideal, that over representation of African Caribbeans in the mental health system needs to be addressed as a matter of urgency, progress can be made. However it has to be more than just a shared ideal.

**Recommendation 1**

**A statutory/voluntary sector compact should be developed with explicit recognition of the roles of the voluntary sector and protocols for joint working.** This should take account of any work already underway in connection with the development and implementation of the national Compact on Relations between Government and the Voluntary and Community Sector, which was adopted in 1998. An honest appraisal of the remit and limits of the voluntary and statutory sector agencies involved is essential. This is a first step to the recognition of complementary roles and that neither the voluntary or statutory sector in itself can be a panacea for the provision of effective services.

**Recommendation 2**
A Mental Health Providers Information Exchange (MHPIE) should be established

It is suggested that an initial step will be to create a database and interactive website for all providers, which takes our typology tables in this document a stage further. That is, all providers in London would be listed with descriptions of what they do, contacts, etc. This will aim to facilitate targeted commissioning, appropriate support for clients and online information exchange between statutory and voluntary sector organisations. The website could also be used to hold e-training packages, policy developments, news items, etc.

Recommendation 3

The ACMHC or another relevant and expert body should work with others to co-ordinate and develop effective approaches to commissioning and to raise commissioners’ awareness of the value of the sector. This may involve a brokerage service for commissioning which matched BVCS service providers to services needed by mental health statutory providers/authorities.

7.2 Sustainability and funding

Time and again our study revealed that provision has a tendency to be territorialised and fragmentary. In addition voluntary sector organisations spend a disproportionate amount of time trying to sustain themselves, fundraising and building their own capacity to deal with the requirements of a contract culture.

Recommendation 4

Discussions should be initiated with NHS commissioners on exactly how much of the Department of Health’s £50 million budget that has been set aside for buying in voluntary sector services will go to the BVCS. We suggest that ACMHC (and others) enter discussions now to ensure an amount is ringfenced for the BVSC which may be based on proportionality to the representation of diverse BME patients in the mental health system.

Recommendation 5

BVCS mental health organisations should be enabled to have increased access to good support. This could include eg; the services of a dedicated fundraiser shared between organisations based in the same area.
Recommendation 6

Funders (statutory and charitable) should consider a work stream that is dedicated to fostering relationships with the black mental health sector.

Recommendation 7

An agreed approach to funding should be developed to increase the sustainability and resourcing of the BVCS. This may take the form of secure medium and long-term funding agreements, which contain a built-in system of review.

Recommendation 8

NHS commissioners should target black and minority ethnic voluntary sector services for any outsourced mental health services for BME communities. A particular focus in this regard should be on those organisations who work with patients of African Caribbean origin. They should invest over a sustained period of time in established organisations with the requisite skills, which have identified a gap in service provision.

Recommendation 9

All funders (statutory and charitable) should set targets to ensure fair and equitable distribution of funds to black organisations, and information on progress should be made available on an annual basis.

7.3 Infrastructure and capacity building;

It is recognised that current proposals for community development workers could undertake the work suggested below across the voluntary sector although we believe that there is a need for a dedicated unit with targeted support for the black voluntary sector. Hence NIMHE, for example, could employ the community development workers but they would have to work closely with the centre. The London race equality leads in NIMHE could take responsibility for this.

Recommendation 10
A mental health development centre/unit should be established for the BVCS. This should be linked to existing regional National Institute for Mental Health in England (NIMHE) development centres in order to maximise use of resources. This BVCS development centre/unit would operate as a second-tier agency with strategic objectives linked to the wider objectives of the national NIMHE programme.

The centre would have the roles of:

- providing listings, alerts and up to the minute information on available funds
- training and support in fundraising applications
- providing templates, advice, training and support for business and strategic planning
- providing templates, advice, training and support for organisational management and development including staffing and financial matters (payroll, budgeting, bookkeeping etc), monitoring and evaluation, quality standards etc
- assisting organisations with marketing and public relations
- negotiating ‘deals’ which enable cheaper goods and facilities (eg by bulk buying stationery)
- negotiating accommodation schemes and joined up working. This may include helping organisations to acquire an asset base
- monitoring and evaluating progress on race related legislation/policy such as the Race Equality Schemes of PCTs and the Department of Health
- developing an operating and online facility
- ensuring the commissioning of services considers and targets the BVCS.

Capacity building for specific needs of asylum seekers and refugees
Our findings indicated a difficulty across service providers in accessing and supporting asylum seekers and refugees. Given the large number of African asylum seekers in London, and the range of needs already highlighted by NHS organisations – this seems to present a serious gap in the sector. However this study did not specifically investigate provision or the difficulties that the BVCS might face in the range of skills needed.

**Recommendation 11**

We recommend a further study to look specifically at the mental health needs and service provision for asylum seekers and refugees. We also recommend that statutory services should engage more actively with BME service users generally, in order to capture their views and experiences about which aspects of service
delivery are valued. We note the work on the National Black & Minority Ethnic Census currently underway; but would also recommend the use of Race Equality Impact Assessments under Race Relations legislation to develop greater information and choice for BME communities.

7.4 Training (of both the voluntary and statutory sector)

Recommendation 12
It is recommended that approaches to training are identified and made accessible to the BVCS. This may take the form of existing training packages or could include the development of a suite of training packages which could be available online as e-training backed up with face to face training where appropriate. The training programmes offered could be targeted at both the voluntary and statutory sectors.

Preliminary suggestions for packages based on findings are for:

• financial skills – budgeting, payroll, bookkeeping, petty cash, fundraising (especially preparing budgets for applications)
• management skills – business/strategic planning, operational and project management, monitoring and evaluation, ensuring quality standards, personnel management, policy preparation, management committee roles and functions, contracting and procurement, equality management
• writing skills – for developing policy and consultation responses, for letters, press releases, presentations

• understanding, using and influencing legalisation – particularly on the Race Relations Amendment Act, Human Rights Act and mental health and related legislation
• people skills – counselling, managing conflict, transcultural communication, dealing with harassment, understanding and working with statutory services
• mental health specific courses
• NHS commissioners could also buy in to any of the above and should be trained in understanding the black voluntary and community mental health sector, discrimination, racism and the need for specialist services for African Caribbeans. Training should be developed and delivered by black voluntary sector organisations.

Recommendation 13
Shadowing schemes should be developed which can work both ways – NHS personnel seconded or placed in voluntary sector organisations or voluntary sector personnel placed in statutory services.

7.5 Partnership and dialogue

The findings and those of other reports reveal that voluntary sector organisations are often stretched almost beyond limits in responding to policy and initiatives emanating from government and local and regional public authorities. It would be of great benefit all round if the black voluntary sector could have longer term engagement models which foster a culture of black communities speaking for themselves and being leaders in the development of policy and practice rather than, as is often the case, reactive partners. To this end we suggest that there is more support and attention to engagement in local and regional health arenas and a standing annual conference or regional conferences which can set priorities and targets for the next year.

Recommendation 14

Recognised local BVCS groups should be resourced to facilitate a critical engagement partnership (CEP). These groups should offer guidance, training and support to understand the various arenas of possible engagement (see Table 7) and influence and could even act as a representative body. Thus after regular meetings with voluntary service providers and users they could take the issues and discussions to the various forums, this would alleviate several groups all trying to have enough time and resources to input to all the necessary forums. One model of operation could be that, for example, from an area where there are say ten voluntary groups, one of the workers or volunteers from each group is part of the CEP and is paid for their time at meetings and work conducted. The group would then arrange between them to send representatives to the various bodies. They would have a mandate to take up and report back on all issues to their own voluntary group and to the wider CEP which would then disseminate the information. This would not replace the ongoing training and capacity building for many more to be involved but would be part of it.

Recommendation 15

Develop a pan-London approach to promoting dialogue and partnership across a range of sectors between those who hold/dispense funds and those who need them. This could:

- facilitate dialogue
- develop opportunities for high level strategic partnerships
• provide a basis and a mechanism for analysing progress towards sustainability of the BVCS

It is important to note, however, that the independence of the BVCS should not be compromised, as this is its greatest strength. Funding and other partnerships must be fair and equitable so that voluntary organisations are not simply steered towards addressing the agenda and needs of the statutory sector, as opposed to those of their service users, in particular African and Caribbean people in London.

**Recommendation 16**

The role of black and minority ethnic community development workers.

It would make sense that the CDWs work closely with the centre/unit suggested in recommendation 10, or are even located within the centre which in turn could be located in NIMHE or ACMHC29. The black voluntary sector should be involved in the discussions around all of the above.

The is in line with Interim Guidance from the Department of Health (2004).

Community Development Workers (CDWs) will be recruited and in place by 2006 to help services take forward work with black and minority ethnic communities. This initiative will form part of the Performance and Planning Framework requirements set by the Government that all PCTs are obliged to meet. Resources for these roles have been worked into every PCT’s baseline budget and it is initially the responsibility of the PCT to actively look at how they should work. The Interim Guidance published on CDWs (DH, December 2004) sets out the framework for local health and social care systems to introduce community development workers in the mental health workforce.

There is a danger of being over-optimistic about what the 500 black and minority ethnic Community Development Workers (CDWs) nationwide (and 83 in London) will be able to achieve. The Interim Guidance describes their role as change agents; service developers; capacity builders and access facilitators. If the role of Community Development Workers is to be flexible and determined locally, then decisions about the focus and priorities of the posts must be taken in partnership with black Voluntary and Community Sector mental health organisations. This would ideally be facilitated by a development centre as suggested above in 7.3.

The salary level of the black and minority ethnic CDWs will be critical to the success of this initiative in developing equitable partnerships with statutory services and building the sustainability of the black voluntary mental health sector. The Interim Guidance suggests a salary level of £25,000. This is broadly in line with our suggestion of a minimum salary of £26,000 plus on costs. As the minimum necessary to recruit appropriately skilled individuals.

CDWs need to reflect the ethnic groups most overrepresented within coercive psychiatric services. A mixture of senior and assistant black and minority ethnic CDWs could be considered.
Recommended responsibilities of the black and minority ethnic Community Development Workers, based on the interviews with voluntary organisations in this study, is outlined below. These reflect our recommendations for the role of a development centre. Key responsibilities:

- Provide practical assistance with funding applications and finding sources of funding – funding should be from both statutory and charitable sources, to diversify the funding bases in the long-term interest of the organisations.

- Broker relations between statutory and black Voluntary and Community Sector mental health services, with a focus on senior commissioners in statutory services.

- Develop coalitions of black voluntary and community sector organisations providing mental health services, in order to develop equitable relationships with statutory agencies and greater negotiating power in public service agreements.

- Foster partnerships between black voluntary and community sector organisations to develop long term joint working and possible joint premises where appropriate and beneficial to the organisations.

This is also in line with the roles for CDWs as set out in the Department of Health Interim Guidance.

References

28 Inquiry into the death of David Bennett: Norfolk, Suffolk and Cambridgeshire Strategic Health Authority

29 If located in ACMHC the emphasis would be firmly on services for African and Caribbean people, whereas within NIMHE this emphasis could be broader across African, Caribbean, Asian, refugee and asylum seeker communities.

8 Support for conclusions and recommendations

Table 6  Evidence for ‘Blueprint’ recommendations

Key issues identified in other reports

Key findings from ACMHC study

- The Independent Inquiry into the death of David Bennett (2003) profiled several black voluntary and community sector mental health organisations and noted that though the projects were all successful, they were relatively small and relied on key staff for their survival.
• Mental Health and Social Exclusion, (SEU 2004) ‘The voluntary and community sector is essential to deliver local services to adults with mental health problems and promote meaningful community engagement. Small local groups are better placed than government to understand and meet local community needs. This is particularly true of people who may be less likely to access statutory services, such as people from ethnic minorities.’

• Black voluntary and community sector funding: Its impact on civic engagement and capacity building (2004) The black voluntary and community sector’s strength lies in its long established tradition of trying to ensure that minority communities can enjoy full citizenship rights and have equal opportunities to participate in British society. The BVCS is still a relatively new partner with statutory bodies, and the importance of the sector is only just being recognised.

• The key message was for the statutory sector to effect a change in mindset, and to view the BVCS as equitable partners who contributed to the development of policy and practice, community engagement and social inclusion, and not simply as service deliverers.

• The main roles of the black voluntary and community sector in mental health were seen as:
  1. The provision of culturally sensitive services and early intervention, resulting in reduction of overmedication, admission or re-admission to hospital. Reaching people statutory services cannot. This is potentially cost saving.
  2. Brokerage and advocacy
  3. Social engagement
  4. Policy influence – including challenging institutional racism

• The importance of black organisations that employ Black staff who understand the social, cultural and political experiences of African Caribbean patients who have used mental services cannot be emphasised enough. Having staff who speak and understand local language, both literally and metaphorically, is very important, especially if people are in mental distress.

Key issues identified in other reports
Key findings from this study
Recommendations
• The Sainsbury Centre for Mental Health (SCMH 2002) recommended that the Department of Health commission a national resource centre to support gateway organisations, which would offer expertise in ‘organisational development, training, knowledge and information’, funding information. It would be centrally funded in the medium term but be accountable
to a Board made up of a majority of representatives from black gateway organisations and the black community.

- SCMH further recommended that the Department of Health identify relevant funding streams for black organisations (such as Section 64 and neighbourhood renewal) and create access for black organisations. Targets should be set to ensure fair access for black organisations, and embedded within mainstream performance management.

- Black voluntary and community sector funding: Its impact on civic engagement and capacity building (2004) The BVCS finds it difficult to access funding and there is an acute need for more transparency in funding. The report recommended that there needs to be a site or institution providing free or low-cost training and capacity building for the BVCS, including payroll services, templates for minutes, strategic and business plans and other managerial and administrative support. The study recommended that work was done to build the knowledge base of both the BVCS and statutory sector about public bodies’ duties under the Race Relations Amendment Act 2000 and the Human Rights Act 1998.

- The lack of long-term funding was often stated as a serious problem affecting the sustainability and growth of BVCS organisations. For many organisations this resulted in an environment of instability for both staff and service users. It was mentioned by several to affect staff retention rates, resulting in loss of expertise and investment in training.

- In most cases projects found it difficult to access funding for their core costs, as opposed to project funding.

- Primary Care Trusts, social services and local authorities were the most common sources of funding for black and minority ethnic mental health voluntary organisations. Social services funding was perceived to be the least secure, lasting only one year with no guarantee of continuation, making planning extremely difficult.

- None of the funding providers that participated in this study had ringfenced funding for black and minority ethnic organisations, although some funders were in the process of developing funds-targeted-black and minority ethnic groups.

- Organisations responding recognised the need to diversify their funding sources. However, few had the capacity to put much energy into this in practice.

- Most organisations found the application process time-consuming and few had access to assistance with funding applications.

• Inside Outside (NIMHE 2003)
  1. ‘Statutory mental health providers must work collaboratively with local voluntary sector in developing a variety of service models to meet the needs of ethnic groups.’ (p 23)
  2. ‘There is community access to the officers of the Trusts on a regular basis’. (p 28)

• Discusses the role of Black and Minority Ethnic community development workers (CDWs), which it sees as involving organisational development, leadership development, identifying local concerns, skill development, supporting local groups to become partners with statutory agencies in developing services, supporting local networks and giving advice on funding sources.

• Community Development Workers for Black and minority ethnic Communities (DOH 2004).

• Guidance provides a framework for local health and social care systems to introduce Community Development Workers into the mental health workforce.
Framework for local health and social care systems to introduce Community Development workers into mental health workforce in accordance with DoH target of 500 in post by December 2006.

Key issues identified in other reports

Key findings from this study

- Black Spaces (Mental Health Foundation, 2003) makes many recommendations regarding the organisational development of black mental health organisations, based on in-depth case studies of seven projects. Its main recommendations for the black mental health sector as a whole are:
  1. Support should be provided to enable small black voluntary organisations to develop into medium or larger organisations.
  2. Students training for mental health work should do placements in black organisations.
  3. Black and mainstream organisations should engage in collaborative work.

A team of black user consultants should be developed, including African Caribbean, Asian and African service users. The team would help develop user involvement in black voluntary organisations.

- On Our Own Terms (SCMH 2003) found that black people were marginalised within the user/survivor movement. It recommended the development of a national voice for the black service user/survivor movement.

- Breaking Circles of Fear (SCMH 2003) recommended that the Sainsbury Centre for Mental Health should facilitate the development of a national voice for the black user movement.

- Organisations that were part of a network were at an advantage when it came to accessing information about funding.

- There was widespread acknowledgement that current capacity building provision was inadequate and that more was needed. In particular one respondent commented that it was difficult to access information about capacity building provision as there was no ‘one stop shop’ to which to turn.

- Fundraising was the most frequently mentioned of all infrastructure development tools, followed by evaluation tools training, human resource, management tools, business development and payroll administration.

- Most organisations had ambitions to expand their services, grow the organisation and provide a more holistic approach to service user needs, including through developing research and dissemination of information.

- Ownership of property should be a goal of capacity building provision to the BVCS mental health organisations.
Key issues identified in other reports

Key findings from this study

- Black Spaces (Mental Health Foundation, 2003) black and mainstream organisations should engage in collaborative work. A team of black user consultants should be developed, including African Caribbean, Asian and African service users. The team would help develop user involvement in black voluntary organisations.

- Inside Outside (NIHME 2003) recommends that:
  - Training of mental health professionals ‘should include service users and/or voluntary organisations working with black and Minority Ethnic groups in their programme.’ (p. 31)
  - Inside/Outside discusses the role of black and minority ethnic community development workers (CDWs), which it sees as involving organisational development, leadership development, identifying local concerns, skill development, supporting local groups to become partners with statutory agencies in developing services, supporting local networks and giving advice on funding sources.
  - The report recommends that black and minority ethnic CDWs need to be linked formally to existing organisational structures and that their work needs to be linked with other mental health service development priorities.

- Availability of mental health services in London (Foster/2003) recommends that health commissioners in PCTs and Mental Health Trusts would benefit from greater support and development of skills in mental health primary care services. This skill development needs to be extended to understanding of the BCVS and why its work is essential in providing services to African Caribbeans.

- All black organisation respondents stated that training was needed in order to deliver the kind of service that they would like to offer over a sustained period of time. In particular knowledge of current mental health legislation and policy was needed, as well as management, fundraising, social work and counselling training. However several organisations stressed that they would not be able to take up increased training opportunities unless staffing levels were improved, as maintaining staff cover for services had to be prioritised.

- Few among the funders surveyed for this study demonstrated a palpable understanding of the importance of the BVCS or the unique set of challenges facing BVCS groups.

Key issues identified in other reports

Key findings from this study

- Black voluntary and community sector funding: Its impact on civic engagement and capacity building (2004) The report identified issues with power imbalances in partnerships between statutory agencies and black voluntary and community organisations. It recommended that where a statutory body partners a black organisation, the early stages must include
agreement on the respective expectations and obligations and on the level of power that each party has.

- Delivering Race Equality, 2003: a Framework for Action lists as one of the statutory duties to deliver race equality that ‘those responsible for planning and delivering services need… to involve and build a partnership with black and minority ethnic communities.’

  - It stipulates that Local Council planners and PCT commissioners should:
    - ‘support the community engagement process of recruiting and developing black and minority ethnic community development workers’
    - ‘inte‌grate consultation with and representation of black and minority ethnic VCS specialist services, community and faith groups into the strategic planning process and key joint planning groups.’

Most respondents were positive about the benefits of partnership working, whether with the statutory sector or other voluntary organisations, and most were involved in/with partnerships of various kinds. The overarching reason for undertaking partnerships was to serve best the interests of their service users

- Small organisations reported that the power dynamic of working in partnership with statutory agencies was challenging as there was often an imbalance. Nevertheless all black voluntary sector respondents said that they would willingly enter into new partnerships if the power of imbalance was sufficiently addressed.

- Organisations spoke of a need for funders to ‘get to know’ the black voluntary and community sector and individual black organisations. It was important to organisations that funders understood that they provided ‘real services’ that were complementary to the statutory sector and vital to the continued treatment of black mental health service users

- The key message from organisations was

  for the statutory sector to change its ‘mindset’, and to view the BVCS as equitable partners who contributed to community engagement and social inclusion of people with mental health problems, and not simply as service deliverers that the statutory sector can call upon as a cheap alternative to statutory provision.

**Key issues identified in other reports**

**Key findings from this study**

  - ‘put in place robust mechanisms to ensure this representation is underpinned by consultation and engagement with the wider community.’

- Inside/Outside (NIHME 2003) recommends that:
  1. ‘Statutory mental health providers must work collaboratively with local voluntary sector in developing a variety of service models to meet the needs of ethnic groups.’ (p 23)
  2. ‘There is community access to the officers of the Trusts on a regular basis.’ (p 28)
3. Training of mental health professionals ‘should include service users and/or voluntary organisations working with black and minority ethnic groups in their programme.’ (p 31)

4. Community development goes beyond forging ‘links’ between voluntary and community organisations and statutory agencies.

5. The report recommends that black and minority ethnic CDWs need to be linked formally to existing organisational structures and that their work needs to be linked with other mental health service development priorities. It stresses that the support, supervision and co-ordination of community development work need further discussion and planning, and suggests that the NIMHE Development Centres could support and sustain the initiative.

• People with senior management roles and strategic vision in relation to the future operation of their agency wished to have the opportunity to engage with the organisations as a partner, but as an efficient partner. This implied both an adequately resourced BVCS and a continuity of collaboration.

Action for black community
Set up or join patient groups and attend board meetings and put black concerns on the agenda.
Join forum to influence the implementation of public policy.

Website
www.napp.org.uk
www.thepatientsforum.org.uk

Meeting attendance
Work in patient participation groups with PCTs to influence the development of more service user led services.
Annual conferences on patient involvement.

Conditions for membership
Anyone with an interest in improving health services and influencing policy and resource allocation. Patients and carers seeking to influence local health practice and policy.

Function
Ensure patients exercise their right to participate individually and collectively in the planning and implementation of health care services.
Patient membership organisation that works to improve communication, consultation and liaison between the health consumer network, government, statutory and professional organisations.
Represents patients and carers in the promotion of discussion about concerns about health and care inequalities in health services organisations.

Acronym
NAPP
Organisation
National Association for Patient Participation
The Patients Forum

**Action for black community**
Set up or join PPIs and attend board meetings to influence policy decision.
Secure invitations onto board meetings through PPI membership.

**Website**
www.cppih.org

**Meeting attendance**
Monthly meetings and attendance on board meetings.
Board meetings are open to the public on a ticket basis only

**Conditions for membership**
Volunteers
in local communities who want to help patients and the public influence the way that local healthcare is organised.
PPI monitoring body which submits report to the Government on how the PPI system is functioning.

**Function**
The Forums play an active role in health related decision making within their communities. Members of PPI Forums are provided with training and development opportunities to enable them to participate effectively. Each PPI Forum is supported by a Forum Support Organisation and the Commission regional centre.
The Commission’s role is to make sure the public is involved in decision making about health and health services in England. To be abolished in the Autumn of 2006 and replaced by a Centre of Patient Excellence, who will monitor best practice and patient advice. It is unclear where the 572 Patient and Public Involvement (PPI) Forums, one for each NHS Trust in England will be placed under the new structure.

**Acronym**
PPI
CPPIH

**Organisation**
Public and Patient Involvement Forums
Commission for Patient & Public Involvement in Health. To be abolished in Autumn 2006.

**Action for black community**
Ensure black patients can access feedback systems

**Website**

**Meeting attendance**
**Conditions for membership**
Not open to the public. NHS staff are responsible for managing the PALS service and it is used to deal with staff complaints and improve community links with service users. The DoH has described PALS as a focal point for feedback from patients to inform service developments so that they act as an early warning system for NHS Trusts, Primary Care Trusts and Patient and Public Involvement Forums by monitoring trends and gaps in services and reporting these to the trust management for action.

**Function**
PALS are a central part of the new system of PPIs, they offer confidential assistance in resolving problems and offer help in explaining often complicated NHS complaints procedures.

**Acronym**
PALS

**Organisation**
Local Patient Advice and Liaison Services

**Action for black community**
Raise awareness about patients rights by disseminating information about ICAS to all black services and community groups.

**Website**
N/A

**Meeting attendance**
N/A

**Conditions for membership**
ICAS is provided on a regional basis by:
- Citizen’s Advice Bureaux
- Carer’s Federation
- POhWER
- South East Advocacy Projects (SEAP)
Advocates are a good point of contact for accessing information on how to address service inequalities.

**Function**
ICAS offers advice and support to people who wish to complain about the NHS. This is a statutory service providing a national service delivered to agreed quality standards.

ICAS supports the principle of local resolution and aims to help clients find a solution as close as possible to the point of the service that has caused dissatisfaction, maximising the chances of the complaint being resolved quickly and effectively.

**Acronym**
ICAS

**Organisation**
Independent Complaints Advocacy Services

**Action for black community**
Black organisations work together to highlight bad practice through PPIs to the Audit Commission. Access and utilise services available from the FSO.

**Website**
www.audit-commission.gov.uk

**Meeting attendance**

**Conditions for membership**
Not open to public membership
Support organisations that do not have public membership

**Function**
Independent public body responsible for ensuring that public money is spent economically, efficiently and effectively in the areas of local government, housing, health, criminal justice and fire and rescue services. FSOs are contracted through a competitive tendering process to support PPI Forums, these organisations, independent of the NHS, use their knowledge, experience and existing contacts within local communities to support PPI Forums. They are single organisations or consortia that play a vital role in helping to shape the future of health provision throughout England. They are managed on a geographical basis by nine regional centres.

**Acronym**

FSO

**Organisation**
Audit Commission
Forum Support Organisations

**Action for black community**
Raise awareness about the use of campaigning to highlight inequalities in care.

Lobby for black representation in both lay and medical membership of the council to push black health inequalities up the agenda.

**Website**
www.popan.org.uk
www.gmc-uk.org

**Meeting attendance**
Seven meetings a year with additional meetings on consultations as they arise.

**Conditions for membership**
Not a membership organisation
Membership:
35 members on GMC:
19 medical members elected by peers; 14 lay members appointed by NHS Appointments Commission: 2 medical members elected by education committee

**Function**
POPAN is dedicated to helping people who have been abused by health and social care workers and working to prevent abuse. They do this by providing a helpline and professional support and advocacy services for the victims and survivors of abuse and by campaigning for improvements in policy law and practice, conducting research and providing education and training. Safeguards the standards of medical ethics, education and practice, in the interests of patients, public and the medical profession.

**Acronym**
POPAN
GMC

**Organisation**
Prevention of Professional Abuse Network
General Medical Council

**Action for black community**
Join PPRG and register interest to attend GMC consultations to voice black patients interests. Black professionals should be encouraged to join as board members to influence healthcare policy at senior level. Write to PCT about creating a service user non executive board appointment.

**Website**
www.gmc-uk.org

**Meeting attendance**
Quarterly meetings with additional meeting on consultations as they arise.

**Conditions for membership**
Patient, voluntary or charitable organisation interested in influencing GMC strategy.
Lay members are invited to join the board of all the PCTs after an extensive interview process.

**Function**
GMC patient and public consultation body.
Responsible for planning and delivering health services and improving the health of the local population. PCTs are obliged to ensure the provision of hospitals, dentists, mental health care, walk-in centres, NHS Direct, patient transport, population screening, pharmacies and opticians. They are also responsible for integrating health and social care.

**Acronym**
PPRG
PCTs

**Organisation**
GMC, Patient and Public Reference Group
Primary Care Trust’s

**Action for black community**
Former black service users, carers and professionals attend both board and forum meetings.
Write to MHT to request a service user non executive board appointment.
Black professionals should be encouraged to apply to boards.
Write to SHAs and the NHS Appointments Commission to request a service user non executive board appointment.

**Website**

**Meeting attendance**

**Conditions for membership**
Lay members are on occasion invited to join the Board.
User Carer Forums set up to voice patients’ concerns
Advertise for lay members as vacancies arise.

**Function**
Provide care and treatment of mentally ill patients both in the community and from hospital.
 Responsible for ensuring that national priorities (such as the Government’s Action Plan for Delivering Race Equality in Mental Health Care) are integrated into local plans.
Develop strategies for local health services and are responsible for ensuring high quality performance. They manage the NHS locally and are the main link between the Department of Health and the NHS.

**Acronym**
MHTs
SHAs

**Organisation**
Mental Health Trusts
Strategic Health Authorities

**Action for black community**
Drive for diversity within trust should encourage black applications.
Write to Ambulance Trusts to request a service user non executive board appointment

**Website**
www.patientsforumlas.org.uk

**Meeting attendance**
Lay persons may be invited to board meetings once it is agreed within the patients forum

**Conditions for membership**

**Function**
Responsible for responding to 999 calls, doctors’ urgent admission requests, high-dependency and urgent inter hospital transfers and major incidents.
Monitor London Ambulance Services NHS Trust on behalf of patients and raise health related issues at a national level. The national organisation represents forums and allows them to work together as part of a wider patient public involvement movement and contribute to national policy and debates on health. The forum should allow forum members and staff to be involved in appraisal and performance review to ensure standards of good practice are implemented.

**Acronym**

**Organisation**
Ambulance Trusts
Patients Forum LAS

**Action for black community**
BME professionals who take up these appointments will have an opportunity to be involved in some of the decisions, which affect services run the community in their daily lives.

**Website**
www.appointments.org.uk

**Meeting attendance**
Once a month occasionally more often

**Conditions for membership**
Responsible member of the public with an interest in health issues and a willingness to devote 5 days a month to non executive duties.

**Function**
Set up to ensure that the NHS involve the public in the process of advising on policies and delivering services which affect us all as citizens.

**Acronym**

**Organisation**
NHS Appointments Commission

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Appendices

Black and voluntary sector mental health services questionnaire

-Funding for Black and Minority Ethnic Mental Health Services Questionnaire - Funders

The 1990 Trust is an independent community organisation conducting a survey on the funding and capacity building needs of voluntary organisations providing mental health care services to the black and minority ethnic community. Our
aim is to develop a blueprint for action ensuring longevity of the black voluntary sector in mental health. Any help you can provide would be greatly appreciated.

This questionnaire is part of a study commissioned by the African and Caribbean Mental Health Commission to assess what gaps exist in current funding and capacity building provision. They are also keen to find out what the key strengths of the voluntary sector are in this area and what will make it sustainable. The Department of Health’s latest report on this subject ‘Delivering Race Equality – A Framework for Action’ has placed greater emphasis on community engagement calling for ‘black and minority ethnic communities including voluntary community services to be more effectively and sustainably involved in planning, designing and commissioning and delivering services’.

The following questions are designed to find out what resources would allow you to provide the types of services you would like to offer. We are also looking for information on how your services are currently funded and how you plan to sustain and or expand on the services.

This questionnaire should take you about 20 minutes to complete.

1 Name of your organisation
2 What are the aims and objectives of your organisation?
3 How long have you been operating for?
4 How did you start up your organisation?
5 Why did you decide to offer the services that you offer?
6 How have you funded the services that you run?
7 How is your organisation currently funded?
8. How do you get information about funding that is currently available?

9. Is information about funding easy to find? Please circle one
   Yes   No

10. Have you ever worked in partnership with, please circle one
    Voluntary organisation   Yes
    Statutory organisations   Yes
    Private sector   Yes   No

11. If yes please name these organisations

12. Why did you go into partnership?

13. Was the partnership successful? Please circle
    Yes Why?
    No Why?

14. Would you go into partnership again?
    Yes Why?
    No Why?

15. How do you find the process of applying for funding? Please circle the options below that apply to you
    Easy    Challenging
    Overly time consuming    Badly designed
    Straightforward    Obstructive
    Complicated    Other, please specify

16. Were you offered help with applying for funding   Yes   No

17. Please describe the kind of help on offer

18. Was it useful? Please circle
Very useful    Quite useful
Not useful      No use at all
19 How many paid staff do you employ?
20 How many people use your service on a weekly basis? Please circle

35 – 50   50 – 100 100 +
21 Please tick the services that you offer
  • Advice/help line
  • Early intervention
  • Counselling
  • Outpatient support
  • Family befriending
  • Support with psychological/emotional issues
  • Assistance with benefits
  • Housing advice
  • Support through hospital admission/discharge
  • Support to carers and families
  • Rehabilitation
  • Assertive outreach
  • Advocacy
  • Medication assistance
  • Supported housing
  • Assistance with practical tasks ie budgeting, shopping, cleaning
  • Advice regarding substance misuse
  • Drop in service
  • Other, please specify

**Capacity building**

The capacity of your organisation is based on the infrastructure, resources and the ability to sustain the services that you offer.

22 What do you see as the role of voluntary organisations in mental health?

23 What do you think is needed to allow black organisations to offer their services on an ongoing basis?

24 Do you think more mental health resources should be moved from the statutory to the voluntary sector?
Yes  No

25 Please give reasons for your answer

26 What do you think is meant by infrastructure development?

27 What is your infrastructure development needs? Please tick one and add others as appropriate

- Management tools
- Fundraising
- Payroll administration
- Evaluation tools training
- Human resources

28 Are you adequately equipped to provide the kind of services that you would like to?

Yes  No

Please give additional information here

29 What opportunities, training or education would you need to deliver the kind of service that you would like to offer over a sustained period of time?

30 What capacity building provisions are currently available to you, ie management training, help with fundraising?

31 Please give the names of the organisation that offer this

32 What capacity building provisions do you use?
33  What capacity building provisions do you need?

34  How do you find out about provision?

   Is it easy to access?  Yes  No

35  If you were putting together a plan for the development of the black voluntary sector for the long term in mental health care what are the key things you would include?

36  Do you have any comments or suggestions?

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**Funding for black and minority ethnic mental health services questionnaire - funders**

-Funding for Black and Minority Ethnic Mental Health Services Questionnaire

The 1990 Trust is a human rights and race equality NGO. We are conducting a survey on the funding and capacity building needs of voluntary organisations providing mental health care services to the black and minority ethnic community. Our aim is to develop a blueprint for action to ensure the longevity of the black voluntary sector in mental health. Any help you can provide would be greatly appreciated.
This questionnaire is part of a study commissioned by the African and Caribbean Mental Health Commission to assess current funding and capacity building provision on offer to black and minority ethnic voluntary groups. We are also keen to find out what funding and capacity building schemes you think will make the sector sustainable.

The Department of Health’s latest report on this subject ‘Delivering Race Equality – A Framework for Action’ has placed greater emphasis on community engagement calling for ‘black and minority ethnic communities including voluntary community services to be more effectively and sustainable involved in planning, designing and commissioning and delivering services’.

The following questions are designed to find how funding and capacity building provision from your organisation can assist voluntary black and minority ethnic organisations in providing sustainable services. We are also looking for information on any black and minority ethnic mental health schemes that you currently fund.

This questionnaire should take you about 15 minutes to complete.

1 Name of your organisation

2 What are the aims and objectives of your organisation?

3 What kinds of funding do you offer?

4 What are the criteria for applying for funding?

5 What is the largest amount of funding and length of time a voluntary sector organisation can apply for?

6 What is the smallest amount of funding and length of time a voluntary sector organisation can apply for?
7. Please give details of any other funding schemes not detailed above

8. Do you get a good response from black and minority ethnic voluntary organisations that offer mental health services? Please circle one option and give reasons why you think this is
   Yes  No

9. Do you offer funding to start up voluntary services? Please circle one option and state why
   Yes  No

10. Do you offer any assistance with the application process? If yes please detail below, if no please state why
    Yes  No

11. How do you make information about funding available?

12. Do you or have you any plans for schemes for funding black and minority ethnic voluntary mental health services?

13. What monitoring and evaluations systems do you have for organisations that you fund?

14. What does this process involve and do you offer any assistance in this process?
Yes  No
If yes please detail below, if no please state why

15  Do you currently fund schemes run by black and minority ethnic mental health voluntary organisations?
   Yes   No
   If you have circled yes to this question please list the names of the organisations you are currently funding.

What services do the organisations that you fund offer? Please list them below

**Capacity building**
The capacity of any voluntary organisation is based on the infrastructure, resources and the ability to sustain the services on offer.

16  How does your organisation define infrastructure development?
17  What infrastructure development training do you offer? Please tick options that apply to you and add any that you offer
   •  Human resources
   •  Business development
   •  Legal business advice
   •  Evaluation training tools
   •  Fundraising
   •  Management tools
   •  Payroll administration

18  Do you offer capacity building training to any black and minority ethnic mental health organisations?
   Yes   No
   If you have circled yes to this question please detail the kinds of capacity building provision that you offer below

19  What do you think is needed to allow black and minority ethnic organisations to offer their services on an ongoing basis?
20 How well used are your capacity building provisions? Please circle one
   Very well    Not so well    Not at all
21 What channels do you have in place for feedback?

22 Does your organisation have any plans in the near future to work with
   black and minority ethnic voluntary and community sector organisations?

23 If so, what do you see are the key areas for development?

24 How is information about capacity building training made available to
   black and minority ethnic mental health groups?

25 Any other comments or suggestions

Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACMHC</td>
<td>African and Caribbean Mental Health Commission</td>
</tr>
<tr>
<td>BVCS</td>
<td>Black Voluntary and Community Sector</td>
</tr>
<tr>
<td>CDWs</td>
<td>Community Development Workers</td>
</tr>
<tr>
<td>CEMVO</td>
<td>Council for Ethnic Minority Voluntary Sector Organisations</td>
</tr>
<tr>
<td>CPPIH</td>
<td>Commission for Patient and Public Involvement in Health</td>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
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<tr>
<td>FSO</td>
<td>Forum Support Organisation</td>
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<tr>
<td>GMC</td>
<td>General Medical Council</td>
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<tr>
<td>ICAS</td>
<td>Independent Complaints Advocacy Services</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>---------</td>
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<tr>
<td>MHT</td>
<td>Mental Health Trust</td>
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<tr>
<td>NAPP</td>
<td>National Association for Patient Participation</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NIMHE</td>
<td>National Institute of Mental Health in England</td>
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<tr>
<td>PALS</td>
<td>Local Patient Advice and Liaison Services</td>
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<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
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<tr>
<td>POPAN</td>
<td>Professional Abuse Network</td>
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<tr>
<td>PPI</td>
<td>Public and Patient Involvement Forum</td>
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<tr>
<td>SCMH</td>
<td>Sainsbury Centre for Mental Health</td>
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<tr>
<td>SEU</td>
<td>Social Exclusion Unit</td>
</tr>
<tr>
<td>SHA</td>
<td>Strategic Health Authority</td>
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<tr>
<td>SLAM</td>
<td>South London and Maudsely NHS Trust</td>
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