Suman Fernando **questions progress in delivering race equality**

Blowing in the wind?

When the report *Inside Outside* was launched in 2003, hopes were raised of better mental health services for black and minority ethnic (BME) communities becoming a reality. These hopes slumped when a proper implementation plan did not come on stream, but revived again when the final version of *Delivering Race Equality* (DRE)[1] emerged in 2005 as an action plan under the aegis of the National Institute for Mental Health in England (NIMHE).

Meanwhile, the government has pursued proposals for radical changes in mental health legislation that are bound to make things worse not better for BME service users – as pointed out by the BME Mental Health Network, 1990 Trust, Transcultural Psychiatry Society and other bodies. To date (December 2005), the draft Mental Health Bill (the Bill)[2] appears set to go ahead virtually unchanged.

DRE assured us that the Department of Health (DH) 'will undertake a Race Impact Assessment on the draft Bill before it is formally introduced into parliament' (page 18). Guidelines for a race equality impact assessment (REIA) – a duty under race relations legislation – are set down by the Commission for Racial Equality (CRE).[3] These include 'formal consultation' with stakeholders (people likely to be affected by the Bill).

Early in 2005, the BME Mental Health Network negotiated with the DH on organising roadshows to provide information on the Bill to BME communities, especially service users and carers. These meetings were fixed for early 2005. It emerged that DH civil servants wanted all information given to participants at the meetings to emanate from DH civil servants alone, while the Network wanted participants to be given a range of views. So the meetings never happened.

In July 2005, the DH appointed an advisory group for a REIA and held a meeting on 28 July with a range of people in mental health as a first stage towards a formal consultation. Then in October 2005, race equality leads (RELs) (see below), who work under the aegis of NIMHE, were asked to arrange meetings in early November for DH civil servants to 'consult' BME service users and carers. This was clearly a tokenistic gesture, something that CRE specifically warns against in their guidelines. It is up to CRE to enforce race relations legislation and insist on a proper REIA being done. But DRE leadership too has some responsibility in this. So far, neither body has taken this on.

So what about the rest of the DRE programme? The first version of DRE, published in 2003, looked to management and performance measures for effecting changes in delivery of services. BME groups pointed out that culture change within services, including the professional practices of psychiatry and psychology, was needed for there to be meaningful change. So the final version included a process to bring about 'whole systems change', based on research funded by NIMHE, and looked to focused implementation sites (FISs) to set a model for change. Since the first version was criticised for not indicating how change will be driven, the final version named the Healthcare Commission, with 'interest' from the CRE, as the bodies that will ensure that it happens.

We cannot judge the final outcome of the DRE programme yet, but we should be interested in progress on the ground. True, money is being spent under DRE. Many jobs have been created. Large sums have been allocated to universities for research and for training workers. Teams of people are being paid for developing training packages. And money is being set aside for evaluation of what happens at FISs and for piloting training schemes. But what is actually happening on the ground?

The nine RELs proposed in the first version of DRE were appointed in early 2004. But they have been hampered by several changes in leadership. The original leader (who was also the author of the first version of DRE that was criticised for, among other things, not being based on consultation) left soon after RELs were appointed. This person was later appointed National Strategic Director of the Department of Health's BME Programme.

His successor, as acting lead of NIMHE's BME programme, then consulted a variety of BME groups and individuals in order to revise the first DRE document. But a new person was appointed to the definitive post in early 2005. Meanwhile, each REL has apparently pursued a variety of initiatives with vigour and commitment. They have supported community groups to carry out community

engagement projects, and they have negotiated with strategic health authorities in selecting FISs. But there is very little indication that their voices are being heeded by chief executives of mental health trusts, who have the power to drive change.

According to the minister who launched DRE, 500 community development workers (CDWs) are the 'frontline troops' for DRE. They were planned as new workers with new money, mentored by RELs but appointed and managed by primary care trusts (PCTs). Although over 179 CDWs were supposed to be in place by September 2005 (or, at least, resources for them are in the baseline [resources] allocation for PCTs), it seems difficult to locate more than a handful of new staff actually appointed as CDWs. In one part of the country where there are said to be 17, none can be found! The likelihood is that resources allocated for CDWs are going towards meeting financial deficits that many PCTs face and/or PCTs are re-badging existing staff. Either way, CDWs as new staff appointed to deliver the DRE agenda are currently difficult to find.

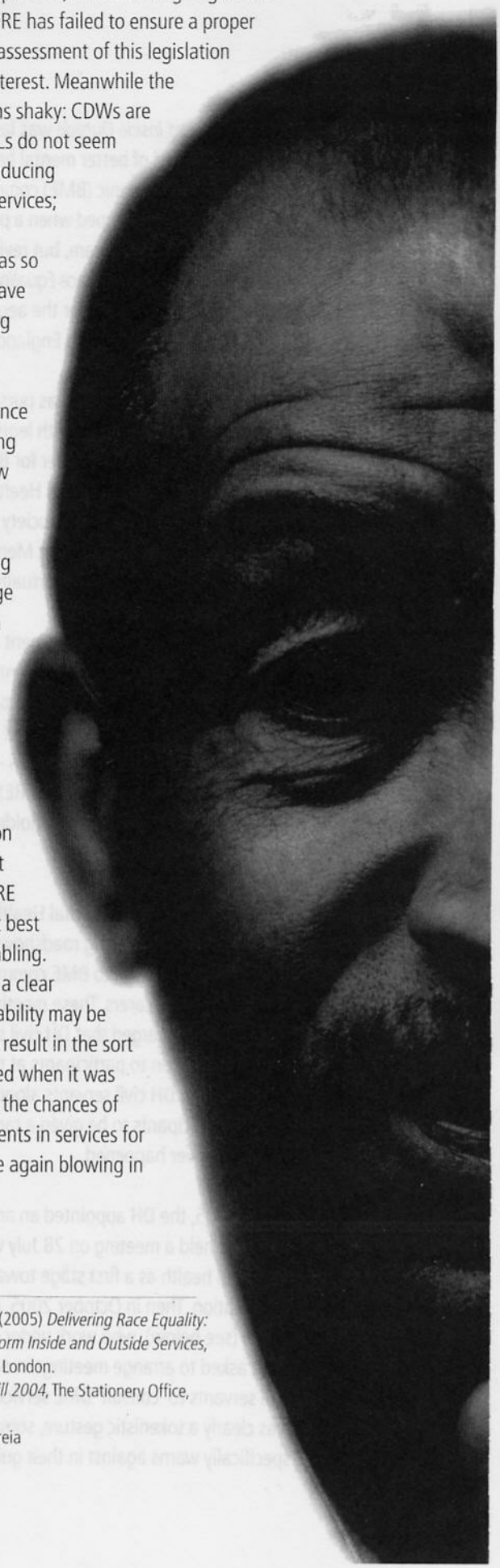
Eleven of the 80 community engagement projects seem to be up and running, and 29 are due to follow soon. Although providing services, they seem to be planned as research projects, with workers being trained as researchers. This puts an additional burden on the RELs who support them in service provision. However, the main problem is about sustainability of the projects after the initial one-year funding is exhausted. Their worth in making any long-term – or even medium-term – impact on statutory services seems doubtful.

The FISs were planned to fast-track appointment of CDWs, try out new training tools for 'cultural competency' and generally develop 'whole systems change'. Seventeen locations have been selected, but there appears to be little agreement in several places as to how they are to bring about changes in delivery of mental health services. Cash-strapped PCTs are unlikely to fast-track new appointments, unless induced to do so by input of sizeable extra resources, not just the one-off £50,000 available for each FIS. 'Race equality and cultural competency' training is likely to be available in late 2006. But we know from past experience that training alone cannot bring about the 'whole systems change' that was promised, and there is no news of strategies for this emerging.

Collection of information is one of the three DRE building blocks. A one-day census of inpatients in mental health services was carried out in March 2005 and a repeat is planned in 2006. A sample survey of quality of care as perceived by BME inpatients is to be carried out shortly. Although this data can help the Healthcare Commission during their inspections, it is the use that data is put to (in improving services) that really matters. There is considerable information already available on racial inequalities, but that has not led to improvement of services for BME communities.

In conclusion, the draft Mental Health Bill, which is likely to exacerbate racial inequalities, seems to be going ahead almost unchanged. DRE has failed to ensure a proper race equality impact assessment of this legislation and CRE shows no interest. Meanwhile the rest of DRE also seems shaky: CDWs are not materialising; RELs do not seem to be impacting on inducing change in statutory services; and most of the new community projects (as so many before them) have little prospect of being sustained.

It seems that any chance of success in improving statutory services now depends on whether schemes for training and strategies to bring about systemic change devised by a research project in London impinge on FISs, and then whether these changes (if effective) will be taken up all over the country. The impression at ground level is that implementation of DRE in many respects is at best patchy, at worst crumbling. Firm action based on a clear definition of accountability may be necessary if DRE is to result in the sort of outcomes envisaged when it was launched. Otherwise, the chances of significant improvements in services for BME communities are again blowing in the wind.



1. Department of Health (2005) *Delivering Race Equality: An Action Plan for Reform Inside and Outside Services*, Department of Health, London.
2. *Draft Mental Health Bill 2004*, The Stationery Office, London.
3. www.cre.gov.uk/duty/reia