

Newcastle Advocacy Centre A Project Of NCVS



Black and Minority Ethnic Case Advocacy Pilot Project

An Evaluation Report Full Report

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This report is an independent evaluation of the Black and Minority Ethnic (BME) Case Advocacy project based in Newcastle Advocacy Centre, Newcastle Council for Voluntary Service (NCVS).

The project was established as a pilot in June 2005 and was funded by the BIG Lottery Foundation for three years. The current funding ends in June 2008. The evaluation will help us develop the project in the future.

The current project provides case advocacy around health and social care issues to four BME communities.

Jill Remnant (an independent consultant, previously employed by the North East Strategic Health Authority) undertook an external evaluation of the project from September 2007 to January 2008. Jill can be contacted by email on: jillremnant@googlemail.com

We very much appreciate the effort, time (over and above our original requirements!) enthusiasm and energy that Jill Remnant brought to this evaluation – thank you Jill.

We have produced both a full report and an executive summary of this report; you can download copies of the report from our website www.csvnewcastle.org.uk/projects/advocacy/advocacy.htm

Or you can contact the project for printed copies.

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1 Executive Summary

The evaluation was commissioned in August 2007 and was required to cover

- An analysis of user and other stakeholder views;
- A review of how this project fits with other services for this group in the city;
- An analysis of the project model;
- Recommendations about improvements to service.

A number of stakeholders were identified by the project and semi structured interviews conducted covering the context of the project, aspects of implementation and the outcomes achieved. Additionally, some work was done with the advisory group to develop an outcome logic model describing the project and to identify future development opportunities for the project. Three other projects providing advocacy to BME clients in relation to health and social care were contacted to provide details of the operational model they used. Five project clients were interviewed with interpreters to gain insight into their experience of the project and the outcomes they felt had been achieved for them. A variety of resources relating to the provision of health and social care advocacy to BME communities were examined to provide contextual background.

During the evaluation a number of strengths of this project were identified including the extensive preparatory work that was undertaken prior to producing a bid for funding. This included seeking the views of community members, seeking to establish what services were already provided in Newcastle for BME communities and specifically which related to access to health and social care; exploring different operational models of provision and engaging with stakeholders about which model would best fit the circumstances in Newcastle. These activities may have taken a considerable time but they provided an excellent foundation for establishing the project once funding was secured. It provides a good example of the bottom up type of needs identification and assessment and positive engagement with relevant stakeholders that is more likely to produce a project that genuinely meets the needs of disadvantaged communities.

Another real strength of the project is the existence of a diverse and engaged advisory group. Its membership includes some of the most knowledgeable people in the city about the needs of BME communities in general and asylum seekers and refugees in particular. This group continues to be a resource to the project in terms of the expertise and support it provides and a resource of the project in terms of using the case study material to promote the advocacy service and influence the statutory services.

The stakeholders were very consistent in believing the need for the project remains high, that there is not another organisation providing similar services and that the relationships between the project and other voluntary sector projects means that the fit with other projects for these communities in Newcastle is a good one.

This is an effective and well run project that delivers the outcomes agreed with its funding body. It has continued to develop during its three year pilot phase and is highly valued by local stakeholders and clients of the service. It is however inadequately funded and operates under great pressure. This may have had an adverse effect on other advocacy services run by the advocacy centre because of the extra time the manager has to commit to the support and development of this project at the potential cost of support to the Advocacy Centre as a whole. Having said that, there have been benefits to the advocacy centre as a whole in having the BME project along side the other services. ***“The project has affected the other advocacy services in terms of increased cultural awareness and sensitivity to BME issues”.***

The project has developed an effective operational model that works in practice, particularly the relationship with the Newcastle Interpreting Service. None of the other operational models examined for this type of project, offered an alternative that appeared to be an improvement. It has been continuously developing over the last two and a half years and now has the effective relationships, capacity with bilingual advocates and support from the advisory group to really make a impact however the pace at which the project is running is not sustainable in the long term.

It has without doubt made a difference to the lives of the clients who have been helped by the project and has in my view, significant potential to really influence practice within health and social care services. To do this effectively it requires the security of mainstream funding and additional resources to ensure that the project can continue to meet the demands of the clients coming forward from the target communities, as well as invest the maximum time and energy required to increase cultural competence in front line services, particularly health services. The evidence available shows that health organisations are still not providing equitable services to all members of the community. This project can make a significant contribution to reducing these inequalities if it is adequately funded and resourced to do so.

2 Acknowledgements

It would not have been possible to produce this report with out the generous contribution of all of those individuals who agreed to speak to me about their experience of the project as well as share their views about possible developments and the future for the project. A list of contributors is included in appendix 11.1.

Others agreed to speak to me about their experience with other different projects and the reasons for using the model that they do.

Some offered resources that they were aware of or had written, which helped provide me with a broader context for considering this project.

The advisory group consented to two facilitated session to develop an outcomes logic model for the project and some proposals for the possible future development of the project.

My particular thanks go to the five clients of the project who agreed to meet with me and through an interpreter share their thoughts about the project and the impact it had on them and their lives. Thank you also to the interpreters who also shared insights.

Both Jacqui Jobson (Advocacy Centre Manager) and Yvonne Cheung (BME Case Advocacy Project Co-ordinator) made available as much time as I needed and answered all my questions with good humour. They also made practical arrangements for me to have access to an initial contact list; project documentation and rooms to meet clients where they preferred to meet at MEA House. Yvonne also gained consent from clients to talk to me, made arrangements for interpreters and booked rooms if necessary.

I am deeply grateful to all of you who have shared their time and views about this project and the wider context and could not have produced this evaluation without you. You have made it a fascinating and enjoyable experience.

3 Terminology used

Many of the terms used in this report do not have a universally agreed definition and some are contested. I have used terms that are generally widely understood but recognise that other people may have different understandings and other preferred terminology.

Advocacy – is when a person makes sure that someone’s voice is heard. This is by speaking up for them or supporting them to speak up for themselves.

Advocacy services should ideally be independent of service provision, to avoid conflicts of interest.

Citizen advocacy – a one-to-one long term partnership between a person who is not in a good position to speak for themselves, and a volunteer Citizen Advocate, a valued citizen who “stands by” them.

Case, crisis or representation advocacy – provides an immediate short term response to an identified problem, event or change in someone’s life. It can incorporate advice, representation and negotiation with the aim of achieving the person’s desired outcome.

Legal advocacy – refers to the activities of lawyers or other legally trained individuals who assist, or act on behalf of, people, to exercise or defend their rights.

Professional advocacy – refers to advocacy undertaken by a paid worker who is trained to deliver advocacy and who usually works with people who need advocacy. It can also refer to the situation in which the advocacy worker is professionally trained in the law or health or social work.

Partner/client – is the person the advocate works alongside amplifying their views and preferences, enabling them to make informed choices by accessing the relevant information. The aim is for the partner/client to have more control over their lives.

Black and minority ethnic (BME) – is a general term used to classify the minority ethnic community. “Black” is a political term denoting people who identify themselves on the ground of skin colour, race, culture and language.

Asylum seeker - is the legal term for a person who has arrived in the UK and has made a claim for asylum under the 1951 Refugee Convention. They are described as an asylum seeker until their claim has been fully determined (a final decision made following appeals).

Refugee - the 1951 United Nations Refugee Convention defines a refugee as: 'a person who has a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion.' In addition the person is outside the country of his/her origin and is unable or unwilling to return to it out of fear of persecution and has been given "leave to stay" in the country they sought asylum in.

Destitution – used in this report to mean “the lack of any reasonable statutory support mechanisms, resulting in the individual approaching charities, faith groups, community and voluntary groups to get help and assistance in accessing some form of daily basic support.”

4 Background

Newcastle Council for Voluntary Service, through its Advocacy Centre, is the host organisation for the Newcastle Black and Minority Ethnic (BME) communities' case advocacy pilot project. During the summer of 2007, they invited expressions of interest to undertake an evaluation of the pilot project. The evaluation was to start in September and a written report of the evaluation was to be submitted in January 2008. The evaluation was to include:

- An analysis of user and other stakeholder views;
- A review of how this project fits with other services for this group in the city;
- An analysis of the project model;
- Recommendations about improvements to service.

The Newcastle BME case advocacy pilot project is coming to the end of a three year funding arrangement with the Big Lottery in June 2008. The evaluation is intended to inform decision making about possible futures for the pilot project as well as providing information to all the relevant stakeholders about how the project is perceived, what improvements can be made in how it is run and how it might be developed in the future.

It is important to state at the outset that as an evaluator I am not neutral, in that I support the concept of advocacy generally and in particular the availability of advocacy for all those groups where there is evidence that they experience reduced access and/or inappropriate services from the statutory sector. However, I believe the methods of evaluation used are objective and the report accurately reflects the views of stakeholders as expressed to me.

5 Methodology

The first step was to identify an appropriate evaluation model for this type of project. The tendency of many evaluations is to focus only on outcomes and in the case of projects working with vulnerable and disadvantaged people, outcomes for clients can be very difficult to assess with any confidence of accuracy. The W.K. Kellogg Foundation, a large funding body in the United States of America, encourages all of the projects it funds to take a more rounded view of evaluation, looking at the context in which the project is set, the process of implementation in developing the project as well as the outcomes achieved by the project. This is the model used in undertaking this evaluation and the section headings in this report reflect the evaluation model used.

The Advocacy Centre manager, Jacqui Jobson and the project co-ordinator Yvonne Cheung were asked to identify the key stakeholders for the project to include members of the project advisory group; health and social care professionals who had dealings with the project; members of community organisations working with the projects client groups and bilingual sessional workers for the project.

Face to face interviews took place with 17 local stakeholders (6 from NCVS; 3 from the voluntary and community sector; 5 health professionals; 1 social care professional and 1 interpreter) and a further 4 interviews were conducted by telephone. A list of people interviewed is available in appendix 11.1.

A semi structured interview format was used to cover the three areas of context, implementation and outcomes. A note was taken of each participant's views and a record produced for analysis. Other contacts were approached but either did not respond or were unable to attend appointments.

It was also agreed that Yvonne would contact a number of project clients to ask if they would be willing to be interviewed as part of the evaluation. Each interview was conducted at the venue the client felt was most comfortable for them and an interpreter for their first language was used. Five clients were interviewed, two from the Chinese community, two from the Iranian community and one French speaking African. It proved impossible to arrange an interview with a client from the Bangladeshi community. A structured set of questions were used to establish the clients experience of the project and their view of the outcomes achieved for them. The details of client's responses are included in the outcomes section of the report.

Two meetings were held with the project advisory group (different people attended the two meetings with the exception of three people who attended both) with the intention of producing an outcome logic model for the project.

This process allows a group to reach a shared understanding of the model of the project, using the headings – for whom (who are the beneficiaries of the project); assumptions (this makes explicit the assumptions underpinning the model); process (these are the activities undertaken by the project); outcomes (these are the expected outcomes of the project both for clients and other stakeholders) and impact (this describes the intended difference that the project will make within its context). Further details are provided in annex 11.4 of this report. In addition the advisory group brainstormed some possible future developments for the project that will require further work and consideration.

Jacqui and Yvonne attended a Department of Health sponsored conference on the 25th October entitled “BME Advocacy and the Mental Health Act”. From the participant list Jacqui identified four contacts she felt would be useful in terms of discussing the model used for BME advocacy services. The contacts were approached by email and as a result Michael McKeown provided a copy of the report that he co-authored “Mtetezi – Developing mental health advocacy with African and Caribbean men” and a further two articles he had written. A telephone interview was conducted with Helen Clark, Director of KAG Advocacy (Kingston Advocacy Group) about their BME advocacy service and its location within wider KAG’s wider advocacy services. Another telephone call was arranged with Alan Wenham the manager of City and Hackney Mind. An email exchange with Cynthia Chui provided information about the mental health advocacy service provided by the Chinese National Healthy Living Centre.

Quotations from documents and papers within the report are in italics and quotations from any stakeholder interviewed are recorded in bold italics to distinguish them from documented resources.

6 Context

6.1 The BME community in Newcastle upon Tyne

Newcastle upon Tyne has a relatively small but diverse Black and Minority Ethnic (BME) population. The Newcastle local authority's mid year population estimates for 2006 (the latest available) record a total population of 270,500 broken down into the following ethnic groups

Newcastle upon Tyne Population by Ethnic Group	Percentage of total population
White	93.1%
Mixed	1%
Asian / Asian British	4.4%
Black / Black British	0.4%
Chinese	0.7%
Other	0.5%

The Newcastle Interpreting Service currently provides interpreters in more than forty languages. The numbers of asylum seekers in Newcastle in November 2007, the latest available figures, were 1498. This number is decreasing over time in line with reducing national figures. The figure for refugees is not known because there is no way of knowing how many people receiving refugee status choose to stay in Newcastle or how many from other places choose to move to Newcastle. Based on a positive assumption of those refugees choosing to stay the number is estimated to be between 4,500 and 5,000. Neither of these figures reflects those people who failed their asylum application and choose to remain in Newcastle supporting themselves in the "informal or underground" economy. There is also a significant migrant population in Newcastle that is increasing, the numbers are not known but as an indication the Rights Project currently is working with about 300 migrants (about 50% of its caseload, three years ago this group represented 10% of its caseload).

6.2 The early development of the project

The origins of the BME case advocacy pilot project are with a small group of people coming together, early in 2000, as the Newcastle Health Action Zone (HAZ) Advocacy and Interpreting subgroup. The group was set up as a part of the Race Area of Special Action (ASA) within the HAZ structure, the Race ASA had identified these services as two of the primary needs of the black and minority ethnic communities within Newcastle. The group originally consisted of representatives from the Tyne and Wear Race Equality Council; the Newcastle Interpreting Service; The Newcastle Advocacy Service, Newcastle Social Services; The Health Development Service and the Health Promotion Service.

Over the next two years a number of activities were undertaken in order to better understand the advocacy needs of local BME communities; to map the level of advocacy offered by existing local community and voluntary sector groups and to explore the available models for providing a BME case advocacy in Newcastle.

Research was undertaken in the Chinese and South Asian communities in Newcastle. The views of thirty five potential services users were sought (22 non English speakers and 13 who did speak English); 18 of the non English speakers (82%) and 2 of the English speakers (15%) required support to get their voices heard when dealing with health professionals. This is in the more established communities in Newcastle and demonstrates a high percentage of need for advocacy services.

From the mapping exercise the group drew the following conclusions

- *“The mapping work has clearly identified a gap in terms of health advocacy and equal access across the city.”*
- *“Health advocacy is generally an “add on” not part of core business. It was recognised that people working within these services are trying to bridge the gap and meet an identified health need. In general it was felt that in the community people would take on a health advocacy role because there is nowhere else for the person to go.”*

The group also undertook visits to combined advocacy and interpreting services in London and Leeds. The visits confirmed for the group that *“promoting access to services is different to both advocacy and interpreting and needs some consideration,”* and that interpreting and advocacy was best undertaken by separate individuals. A subsequent feasibility study into the provision of a service promoting access with the use of escorts, said in its interim report (Stacey and Brown) *“By and large, the community groups favoured a service in which the roles interpreter, advocate, and escort were combined in one person. Professionals favoured a separation of the services”*.

In its report dated August 2001 the Advocacy and Interpreting Subgroup made the following recommendations:

- *There should continue to be an independent interpreting service, but the role of interpreters should be further developed. We would not envisage interpreters becoming advocates, we would want to reinforce their role in providing cultural awareness to health professionals during interviews and ensuring clients are able to access advocacy when needed.*
- *We need to build on existing advocacy provision and expertise within the city. This will mean the employment and training of bi-lingual advocates by a recognised advocacy provider. There is a need for access to interpreters who are trained to work with advocates.*
- *Advocates would be involved in ensuring local people were aware of these services and how too access them*

- *It will be important for the two services to work closely together and with health professionals and community workers to ensure clear understandings of roles and pathways of referrals.*
- *Training and awareness sessions should be offered to health development workers, community workers, interpreters etc and their role in advocacy clarified*
- *There needs to be careful development of this project allowing time for the development of a quality service.*

It further recommended that wider consultation take place to secure involvement and ownership of the solutions.

The project really began to gain momentum in 2003 when a workshop was held for a variety of stakeholders to consider a range of possible models for delivering an advocacy service. Six different models were proposed:

1. advocacy and interpreting provided together
2. advocacy provided by community workers/professionals – already existing
3. advocacy provided by community members (friends, relatives) on a voluntary basis – already existing
4. advocacy provided by an established black and minority ethnic project/service
5. advocacy provided by the existing advocacy service (the development kept separate from the interpreting service)
6. advocacy provided by the existing advocacy service working closely together with the interpreting service.

There was overwhelming support for model 6 from the workshop participants.

Following this agreement on a model an outline proposal was produced in the first instance for an application to the Community Fund, which subsequently became the Big Lottery Fund. Following discussions with the potential funder the project had to be scaled back from the original proposal because the potential funder could not fund at the level of the original costings. The main changes were a significant reduction in the level of management support for the project; a reduction in the number of beneficiaries and the proposal to pilot the service with four communities (two established communities i.e. Chinese and Bangladeshi communities and two refugee communities i.e. Iranian and French speaking Africans).

The need for the project had been established well before it started to operate. As part of the evaluation it was necessary to check whether the needs had altered in any way or if other services had come into being which duplicated those of the BME case advocacy project.

To check the perception of the people interviewed, all were asked if they thought the need still existed and/or if they were aware of other similar services meeting the needs of the groups targeted by the project. Without exception all of the local stakeholders interviewed felt that the need for a service in Newcastle that provided BME case advocacy in health and social care remained high. This is in the context that they all work in some capacity with BME communities or specifically with asylum seekers and refugees.

“there is absolutely not anyone else providing this service – the WEST End Refugee Service provides some practical support and the Rights Project can provide advice but not ongoing advocacy in complex cases.”

“there would be a huge gap if the project stopped especially in terms of mental health.”

“there is still definitely a need for the project and for it to be broadened.”

“if it were to fold it would be a loss to the city.”

“there is a definite need for the service.”

“there is a demonstrated need for this type of project and I would like to see a future for it.”

“for this client group [asylum seekers] there are very, very few services available – e.g. an eight months pregnant woman is not receiving any support except advocacy. The North East Refugee Service is overwhelmed with people queuing from 5.00am.”

“not aware of anyone offering similar services in Newcastle.”

“there are no other resources so the needs are still there. Some communities are not very large but have very high needs and no community workers.”

“it is important that the service is available, especially those seeking asylum need practical help and support.”

“there are no circumstances reducing the need – escort service accompanying people to health appointments would help, there was a feasibility study but no funding is available.”

“I’m not aware of any other North east provider – but there is some informal advocacy by local groups [in the context of mental health] – they could be given additional training and support. My impression is that in other areas the advocacy support doesn’t reach BME communities although there is increasing awareness of the need for this.”

“ it is a really positive service to have in Newcastle.”

These views are further supported in the report by Julian Prior **“Destitute and Desperate: A report on the numbers of “failed” asylum seekers in Newcastle upon Tyne and the services available to them.”** Commissioned by Open Door (North East) – April 2006, that estimated:

- More than 300 destitute asylum seekers in Newcastle
- With 20 to 30 sleeping rough overnight
- Thousands more are estimated to have failed their asylum claim yet are still living in Newcastle and are supporting themselves by working illegally.

The same report referred to the BME advocacy project as one of 16 projects that were providing services in Newcastle for failed asylum seekers, although none of the others specialised in health and social care advocacy.

My conclusion therefore, is that there is still a high level of need for this project in Newcastle. No one I spoke to is aware of other providers of professional case advocacy for BME communities in the context of health and social care. There may be some informal advocacy undertaken by local voluntary and community groups working with BME communities and there may be the opportunity to offer some training and support around advocacy to them as part of future development of the project. The project also fits well with other projects and agencies seeking to provide help and support to these communities as later sections on partnership working reflect.

7 Implementation

7.1 Breakdown of project beneficiaries

Since the project became operational in June 2005 with the appointment of the project co-ordinator, one hundred cases and seventeen cases (64 % of whom are female) have been managed by the project. Eighty nine of these cases have been closed as the issues raised have been resolved or it is acknowledged can not be taken any further. This total exceeds the original target of twenty in the first year and forty each in the subsequent two years of the project. The following breakdown shows the community, age, and status backgrounds of the project beneficiaries. These figures are all taken from the monitoring return up to 19th December 2007. Not all of the totals equal the one hundred and seventeen clients as in some cases the relevant information is not available.

Advocacy partners by ethnic community and language	Numbers of advocacy partners since June 2005	Percentage of total
Bangladeshi (Bengali and other)	10	9%
Chinese (Cantonese and Mandarin)	40	34%
Congolese (French, Lingala and other)	28	24%
Iranian (Farsi and other)	26	22%
other	13	11%

Of these 72 (62 %) required an interpreter, which suggests that these clients might experience particular difficulty in accessing health and social care services.

The higher numbers of Chinese community clients reflects the focus on this community when the coordinator was first appointed. The requirement was that the coordinator spoke one of the four languages of the target communities and the successful applicant spoke Cantonese. It was therefore relatively easy to gain access to groups and venues where clients might be contacted and word of mouth referrals has meant clients from this group continue to come forward.

It has proved much more difficult to establish the appropriate links with the Bangladeshi community and clients from this community are underrepresented in the total project numbers. It is understood from other agencies seeking to work with this community that gaining access is difficult e.g. Age Concern. Recently two Bengali speaking bilingual sessional workers have been recruited and the project has planned some further joint work with the Newcastle Health Development Service to try to provide information to this community about the services that are available to them. It is recommended that further targeted activity be undertaken to increase client numbers from this community.

Advocacy partners by age group	Number of advocacy partners since June 2005	Percentage of total
18 – 25 years	12	11%
26 – 50 years	65	58%
51 – 64 years	22	19%
65+ years	14	12%

The age profile of clients cover from 18 years through to over 65 years with just over half being between the ages of 26 and 50 years old.

Advocacy partners by status	Number of advocacy partners since June 2005	Percentage of the total
Asylum seekers	12	10%
“Failed” asylum seekers	35	30%
Limited leave to remain	7	6%
Indefinite leave to remain	2	2%
Refugee with 5 years to remain	11	9%
UK Citizen	33	28%
Other	17	15%

Thirty five of the clients (30%) fall into the category of “failed asylum seekers” placing them amongst the most vulnerable and disadvantaged individuals in Newcastle, because of the lack of practical support available to people with that status. They also represent a heavy demand on advocacy time because of the range and extent of their needs. Over 50% of the clients of the project are from the broader group of asylum seekers or refugees.

Health or social care issue	Number of advocacy partners since June 2005	Percentage of the total
GP	14	14%
Hospital	10	10%
Health care	29	30%
Community care assessment	12	12%
Aids and adaptations	6	6%
Day services	8	8%
Information	19	19%

Over fifty percent of the clients recorded, required direct assistance with health service access or use and it is not known how many of the nineteen cases requiring information referred directly to health issues.

Everyone who contacts the project for advocacy assistance whether directly or through the project outreach activities is assessed to establish if they meet the project’s criteria. The total number of cases rejected by the project is not known because a record of those cases that were signposted to other agencies, organisations or groups was not kept originally. It became apparent however that some of the signposting was taking considerable time and therefore a record was taken of those cases where substantial work was undertaken to effectively refer people on to the relevant bodies. Since this recording began these high intensity cases have totalled 19, with the following breakdown of reasons for referral:

Reason for rejection of case	Number of cases rejected	Percentage of the total
Not a Newcastle resident	4	21%
Education issue raised	1	5%
Housing issue raised	5	26%
Immigration issue raised	5	26%
Welfare rights issue raised	1	5%
Other	3	16%

This is of course an understatement of the projects activity in terms of signposting as only those taking a considerable time are currently recorded. The project complies with the Community Legal Services Quality Mark and their policy is not simply to give people a contact number for other agencies but to actively contact them on the client's behalf, ensuring they have an understanding of the context for the individual being referred and making sure that the contact is actively made. This can be time consuming but is likely to significantly increase the chance that the client will get the help and assistance they need. It is recommended that the project keep a record of all the cases signposted to other agencies, organisations or groups in order to more accurately reflect the project activity.

7.2 The project operational model

One of the elements of the evaluation specification requested was to consider whether the model used in this project is the most appropriate and to make comparisons with other projects elsewhere that are providing advocacy services relating to health and social care to local BME communities. Three other projects offering advocacy to BME communities in relation to health services were contacted and they provided information about their services and the way they were delivered. None of these projects were directly comparable although they had some things in common with the Newcastle BME Advocacy project.

The areas of interest were the focus of the advocacy; client groups, staffing; use of interpretation; method of evaluation and location of advocacy service.

Two of the projects have a particular focus on mental health advocacy (National Chinese Healthy Living Centre and City and Hackney Mind) and the third offers general advocacy and will address any issue the client raises (KAG advocacy).

The former concentrates on the Chinese community across the whole of London and the latter two have London Borough boundaries but deal with a variety of BME communities within that area. City and Hackney have a high ethnic minority population engaged with mental health services and the Mind project has approximately 40 - 50% of its community referrals; 70 - 80% of hospital referrals and a further 70 - 80% of forensic referrals from BME communities. In contrast the ethnic minority population in Kingston and Richmond where KAG operates is approximately 7 – 8% and more directly comparable with Newcastle.

In City and Hackney Mind project the BME advocacy is part of the mainstream mental health advocacy because they failed to secure funding for a BME specific service. KAG has had funding for their BME project for the last seven years but is finding it very difficult to secure continuing funding for this work as funders priorities are shifting and now include things like the provision of legal advice and assistance into employment. KAG established their BME specific project after feedback from stakeholders suggested they were perceived as “Eurocentric” and they felt they had very low numbers of BME clients for their general advocacy service. The Chinese Healthy Living Centre has always offered mental health advocacy to their community whenever the funding has been available.

The Chinese Healthy Living Centre has one Chinese paid worker (the only Chinese mental health advocate in London who carries casework) and does not have either volunteers or sessional workers to support the project. In the case of City and Hackney Mind there are a small team of white part time advocates with a number of volunteer advocates from BME communities. KAG now have one fulltime BME worker and no volunteers or sessional workers.

The Chinese advocate both interprets and advocates for clients and does not regard this as an issue believing it allows for consistency and progress in each case. City and Hackney Mind have no separate funding available for interpreters but the NHS interpreting service can be accessed for hospital inpatients when necessary. KAG does not have access to separate funding for interpreters and has to use client’s family members or volunteer interpreters from KAG or other sources.

All the projects approach evaluation differently; the Chinese Healthy Living Centre has a recording sheet of each meeting between the advocate and client and a “Monitoring and Research Officer” who interviews service users and professionals involved in cases. They have quarterly meetings with their funder and a specific evaluation method is still to be discussed. The City and Hackney Mind manager has access to monitoring information on ethnicity of clients and contacts all clients (by questionnaire or telephone depending on literacy) to ask about access to the service, the outcomes they achieved and the general support provided by the project. He wishes to develop an evaluation tool that would provide robust data on clients experience and the impact of the service. KAG seek feedback from community groups they work

with and other stakeholders and this is considered at an annual review meeting with the staff and management committee.

In the case of both City and Hackney Mind and KAG, the manager's view is that the BME service benefits from being located within an advocacy service hosted by a voluntary and community sector organisation. This is because of the access to training, supervision and support in relation to advocacy and the capacity for all the different advocacy services to learn from each other. It also means the service is provided independently of the statutory service provision and thus is likely to generate more trust and confidence in the potential clients of the service. Both of these services see a clear distinction between advocacy and interpreting activities but do not have the same sort of close relationship with an interpreting service enjoyed by the Newcastle project.

As reported earlier the Newcastle model was selected by a range of stakeholders at a workshop where six alternatives were considered. The benefits of the model of locating a BME case advocacy service within a voluntary sector host organisation that is experienced in the delivery of advocacy are obvious in terms of access for advocates to training, support and supervision. It also provides the independence from the statutory services that is considered necessary to advocate freely and effectively on behalf of the client. The location of the host organisation within the voluntary sector also enables effective networking with other organisations and groups within the voluntary and community sector because of a shared understanding of the constraints the sector works within.

There was a clear decision taken to keep the functions of advocacy and interpreting separate because of the difficulty of one individual being able to switch effectively between the two very different roles whilst keeping the client constantly informed about which role is being undertaken at any particular time. It can be done, but is potentially confusing for both the client and any health and social care professional in the situation.

The Advocacy Standards Framework for Black and Minority Ethnic Communities states "*The role of an advocate (who provides health and social care advocacy) is to inform, empower and represent the interests of the service user to improve access to health and social care services, and to improve health and social care outcomes.*"

"The role of an interpreter is recognisably different from that of an advocate, as an interpreter is paid to be impartial and communicate a message between professionals and users".

This view is reflected by five of the stakeholders interviewed:

“We considered a model with interpreting and advocacy being offered by the same person. Members of the group visited one or two projects but felt that it is difficult to do two things and that it wasn’t really working when projects are being both interpreters and advocates.”

“It is essential to be clear about the service that interpreters provide (aiding understanding and communication) and advocates (who stand in someone’s corner)”

“It is a definite plus for people to have both an advocate and an interpreter, an interpreter has to be neutral but an advocate speaks up for the client”.

“The specificity of the model of advocacy has been essential – most health professionals do not understand advocacy and can not see the difference between advocacy and interpreting.”

“Some health professionals try to avoid the costs of interpreters and ask the advocate to interpret.”

There was additional support for other aspects of the model expressed by stakeholders:

“Independence is essential in terms of management. The community doesn’t mind about the model used.”

“It’s a model that works – they have taken on new communities where there isn’t an advocacy workforce but they have taken on bilingual sessional workers and taught them to be advocates.”

“Employment of sessional workers is good as it provides some employment and builds capacity within the community.”

“The model is good – advocates have training and supervision; there is confidentiality and trust and the service is respectable. Separation from the community is a strength.”

As part of the evaluation other possible models for the service were examined. The model advocated by the “Mtetezi – Developing mental health advocacy with African and Caribbean men” was for advocacy to be provided for this particular community from local voluntary and community organisations who had already built trust and credibility within the community. A challenge with this model is ensuring the quality and consistency of the advocacy process and establishing links with advocacy bodies that have expertise in the delivery of effective advocacy. Another difficulty relates to the size of the BME population and target groups and the number and capacity of the voluntary groups that support them.

In my opinion a particular strength of the Newcastle model is the very clear separation of the advocacy and interpreting activities, coupled with the very close working relationship with the Newcastle Interpreting Service. This results in joint training, the sharing of information and protocols and allows each service to promote the other to statutory service providers who do not always understand the distinction. Although the other projects contacted shared some of the strengths of the Newcastle Project, they did not in my view have a model of delivery that is superior to the Newcastle Project. They all share similar challenges around sustainable funding; influencing improved statutory service access and delivery and robust evaluation of advocacy service outcomes and impact. The role of the advisory group in informing the project and also supporting it in seeking to influence statutory services was another element that makes the Newcastle model so successful.

7.3 The Advisory Group

The Advisory group has a membership of relevant individuals who are well informed about the needs of the BME community in Newcastle and collectively have a vast experience of providing services to the more vulnerable and disadvantaged members of local communities. There is a mix of community organisation representatives and health and social care representatives.

Many of the stakeholders see this as a key strength of the project:

“The steering group [advisory group] has key people involved.”

“there is a good mix of members on the group.”

“People feel obliged to attend advisory group meetings to keep the group informed about new issues in terms of work. The role is not about supervising the workers or the project, it’s more about partnership working than anything else.”

“Members of the advisory group take it seriously and they are taken seriously, e.g. social services provided a written response within a few days when an issue had carried on for about four weeks.”

“ Once the model was developed it needed different people on the advisory group.”

“When a gap in services is identified they proactively follow up on issues and feed them into the advisory group. It is a good advisory group with lots of relevant people involved who use the information in their work.”

“Yvonne can also access advice from members especially to do with asylum seekers. Failed asylum seekers have the greatest needs.”

“Project is worthwhile – which is why people stay engaged. The advisory group feel it has just started to take off.”

“The project provides the advisory group with the monitoring reports; oral feedback and case studies with a wider strategic importance. It is useful to understand the issues they face and sometimes someone needs to take action. “

“We receive feedback on referrals, case studies etc so feel outcomes are being met.”

In my opinion the advisory group is an asset to the project in terms of the expertise available within it and the provision of intelligence about the particular communities served by the project as well as identifying need in other communities. The members are committed to the project and use information gleaned from it to try to influence service provision and are therefore also an asset of the project.

7.4 Administration of the project

The pilot project recruited the full time co-ordinator in June 2005. The Advocacy Centre already had a range of operational policies and procedures and a computer system designed to operate its Citizen and Mental Health Case Advocacy services. The policies and procedures included: “Conflict of Interest” policy; “referrals” policy; request form for BME advocacy; BME case referrals procedure; referral procedure diagram; consent form for information to be disclosed; referral form for organisations; and a letter to partners when they are entered on the database. There is a perception by at least one of the bilingual sessional workers that their may be too much paper work and that the sessional advocates would benefit from a better understanding of the project administrative system.

One of the early activities of the coordinator was the development of an evaluation method. This consisted of a pre advocacy questionnaire which sought to identify the level of the individual’s confidence to undertake certain actions in relation to health services e.g. talking to a family doctor; expressing wants and needs and making a complaint. After the advocacy service had been provided a post advocacy questionnaire using the same confidence indicators and scale was issued. The experience was that these questionnaires were not being completed by clients and there was an extremely low response rate.

An alternative was developed where a BME case advocacy goals report was produced for each client listing ten possible outcomes. The intention was that clients would identify during assessment which goals they wished to achieve (this required some interpretation by the advocate because often client goals would not necessarily be expressed in advocacy terms). At the end of the advocacy process the coordinator would ask which goals the client felt had been achieved (again some interpretation would be required about how their outcomes fitted into the ten specific categories).

There is space on the manual form for the advocate to record exactly what the client wants to achieve underneath the ten headings and an additional space headed notes that could be used to capture evidence of outcomes achieved. Some of the forms examined had insufficient detail to see what the outcomes desired and achieved were. This is obviously a shorthand method of recording, presumably because of time pressures and because the coordinator knows the details of the case. However, it does not allow anyone else examining the documents to form a view about whether or not the goals have been achieved. It is also desirable that the person asking the client about whether they have achieved their goals and whether they are satisfied with the advocacy service received should not be the coordinator, particularly in cases where they provided the advocacy.

I noted that a number of records designed at the beginning of the project were no longer completed because of pressure of work and time and it may be timely to conduct another review. I recommend that a review should be undertaken of the project administrative processes with a view of reducing it to the absolute minimum consistent with effective delivery and monitoring of project activity and specifically that activity recording does not understate the level of activities undertaken or the amount of resources needed to deliver them.

I further recommend a review of the ways achievement of outcomes for individuals are monitored by the project. Also the Advocacy manager should have an independent monitoring role, perhaps by selecting a sample of clients from the project for evaluation and interviewing them to understand their perception of the outcomes achieved and the quality of the service provided. Obviously this has implications for the capacity of the project and particularly the management time available.

7.5 Bilingual sessional advocates

The project has taken the decision to recruit and train as advocates bilingual members of the target communities. This has the advantage of increasing advocacy capacity within those communities and providing some employment opportunities for community members, although this is necessarily limited and the expectation is that the sessional workers would undertake ten hours per month, although in reality they are doing more than this, often significantly more.

All of the sessional workers recruited have received training including coverage of advocacy, issues about confidentiality, referrals procedure and working with interpreters. This training has been accredited by the Open College Network which will fit with national proposals about developing advocacy capacity and competence in developing Independent Mental Health Advocates.

The bilingual sessional advocates all receive individual supervision and support managing their case load from the coordinator and feel supported in their role. They also meet as a group to discuss issues relevant to the service as a whole e.g. the development of a code of practice for advocates. They have begun to work across communities so that they begin to gain an understanding of the cultural context in the different communities and this allows the service greater flexibility in making the most effective use of this resource.

Clearly the development of bilingual sessional advocates has had a significant impact on the role of the coordinator within the project. Recruiting, selecting, training, supervising and supporting the current seven bilingual workers is a very different activity from undertaking all the advocacy and promotion of the service personally. The coordinator has developed into this new role well and only becomes involved in the more complex advocacy cases on a personal basis but supports the sessional workers to develop further their skills in handling the more difficult cases.

7.6 The BME project in the context of wider advocacy services.

Earlier in the report reference was made to the benefit to the BME case advocacy project in being located within a wider Newcastle Advocacy Service in terms of maintaining the quality standards of the advocacy provided by means of training, supervision and the sharing of learning across the different advocacy services and models. The Newcastle Advocacy service provides citizen advocacy and mental health case advocacy as well as supporting the advocacy network. The BME case advocacy project is the only one to employ sessional workers rather than use volunteers and although they are required to be bilingual, the activities they undertake are similar to those undertaken by trained volunteers in the other services.

There have been internal referrals from the BME case advocacy project to the mental health case advocacy project and those cases are perceived to be more complex both because of the very high levels of need of the individuals and the language difficulties. There is also a view that some of the people referred would not necessarily have come directly to the mental health advocacy team without a first contact with the BME service. One worker confirmed ***“I came with some knowledge of cultural issues and diverse communities but the BME project has increased my learning around these issues and that is from a high base.”***

Similarly the BME case advocacy project has access to a lot of knowledge and expertise around mental health services and issues and the sort of issues arising from the citizen advocacy services and advocacy network. Being part of a wider team of skilled advocates also gives the coordinator access not just from management support and supervision but also peer support from colleagues.

8 Outcomes

8.1 Project Outputs and Outcomes Agreed with the Big Lottery Fund

The following is a list of outputs and outcomes for the pilot project to deliver agreed with the Big Lottery Fund. This list is less than the list of outcomes stated in the original bid submitted to the Big Lottery Fund in January 2005 but the level of funding provided was significantly reduced from the original application.

Outputs

- Provide at least 20 advocacy cases in year 1 and 40 in years 2 and 3
- During advocacy cases at least 100 people will be supported in gaining information about their circumstances and learn how to use this.
- Training and awareness raising sessions will be provided – these were about advocacy and to be provided to both BME communities and health and social care professionals.

Outcomes

- Individuals from BME communities will have better access to health and social care services.
- Individuals from BME communities will improve their self confidence and gain increased knowledge about their rights.
- Health and social care professionals will gain a better understanding of non English speaker's needs.

For an assessment of achievement of outputs and outcomes required by the Big Lottery Fund see Appendix 11.7 on page 58.

8.2 Outcomes for individuals

The evidence about outcomes for individuals arising from the project has come from both the information provided by the clients and feedback to local stakeholders from clients of the project.

The project clients interviewed came from the Chinese community (2), Iranian community (2) and one from French speaking West Africa. One had been here for thirty seven years, the others for three years; two and a half years and two years (2). Four were female, one male.

In response to a question about who they would go to if they needed help, two said they would ask friends; two said they would go to a community organisation and three said they would go to Yvonne.

The five clients of the advocacy project interviewed described some of the outcomes achieved for them:

- Four had been accompanied to hospital appointments
- Two were registered with GPs
- Two received help applying for disability status and/or benefits
- Two received help applying for additional income (one in relation to a child; the other because they were destitute)
- Two received help enrolling to study English
- Two had been helped to get accommodation
- Other areas of help referred to included: booking interpreters for health appointments; finding and communicating with a solicitor; linking to social services; renewing an identity card; completing a driving license application form; obtaining a bus pass; tips on son's education; something to do with a bank account and reading official letters.

There may of course have been other outcomes for these individuals but these were the ones they mentioned to me in answer to my questions. One of the issues here is that clients will raise issues that may be considered to be outside the health and social care remit of the project. Because of the relationship of trust developed between the advocate and the client, the advocate tries to help them if they can. This can lead to a blurring of the boundaries of what "health and social" care covers and at least one stakeholder recognised this as a potential issue for the project. ***"They are very clear about what they do but can be drawn into helping in other areas."*** It may be helpful therefore to clarify with project staff the boundaries of what is meant by "health and social care" in terms of the activities of the project, this should then be discussed with relevant stakeholders.

A number of the local stakeholders were able from their own experience to validate outcomes for individuals from the project:

"I personally know of three clients who have accommodation as a result of Yvonne's efforts."

"I have had feedback that some clients have been helped to get Section 4 support"

"Two partners have gained in confidence e.g. a woman rang the hospital herself to ask for an interpreter."

"I had a personal example where a client talked about the outcomes that had been achieved for them and it matched an anonymous case study that Yvonne had given the advisory group."

"An elderly couple have fed back to me that Yvonne had helped them and the service was good."

"I have had positive feedback from mutual clients e.g. help getting accommodation sorted out and help in accessing Section 4 support."

“I know of a French speaking service user who was only provided with information about the Mental Health Act and their rights in her own language because of the persistence of the project.”

8.3 Outcomes in terms of influencing statutory services:

A number of stakeholders have referred to the awareness sessions run for health and social care staff by the project and in some cases this has resulted in referrals from informed staff. The project has also been successful in influencing on a wider stage and the specific example referred to above demonstrates this.

A failed asylum seeker was admitted to mental health services under the Mental Health Act and although she was provided with an interpreter at the time she was not provided with the relevant information in writing in her own language i.e. French. The advocacy project raised the issue of equity following research that translated information was not widely available. The issue was picked up regionally by the “delivering race equality project” and raised nationally, it has resulted in the Department of Health acknowledging that the information available in different languages is not currently adequate and the situation is being reviewed.

Local stakeholders commented:

“They offered to come and talk to the whole team about advocacy.”

“Social workers who work with asylum seekers are aware of this project.”

“Some services have been challenged by the project – a client who had been refused asylum told the project that he was only seen for ten minutes and not given a proper assessment and the project asked for clarification about this.”

“You really need to know the cultural “rules” for different groups – project is really helping.”

“Project is a hugely useful resource – to understand issues; having expertise on what the clients are experiencing and looking at case studies.”

8.4 Other project outcomes – strategic use of cases studies

Two stakeholders referred positively to the use of anonymised case studies for use with the advisory group to draw attention to strategic issues arising from case experience. This provides the opportunity for all the advisory group members via their networks to use the case study material in seeking to influence statutory services.

“Very effective use of case studies in various forums e.g. issue of not using interpreting support appropriately and a child was removed from an appropriate cultural and language environment.”

“They make very good use of case studies – Jacqui and Yvonne are both able to pick up issues for health from their cases – able to provide details about strategic issues.”

8.5 Other project outcomes - Partnership working

A number of the stakeholders interviewed, both from the voluntary and statutory sector referred very positively to the nature of the relationship they had with the BME Advocacy project. This is clearly something that the project invests time and effort to sustain.

“They contribute to the Rights project”

“I support the advocacy project as a way of supporting the Interpreting Service.”

“We refer in both directions. Yvonne is really good and her referrals are always appropriate, unlike some GP referrals.”

“Yvonne has referred clients of hers suffering from anxiety and depression, to the primary care mental health team.”

“They certainly take the pressure off me but it isn’t a duplication of my work. There has been increased demand in the last two years.”

“I met Yvonne early on and tried to fit the project in with the FIS project. Wanted to make sure that advocacy fits into FIS work and Jacqui is on our management group.”

“Project has been very supportive of HAREF and its development.”

“The partnership work is very effective and the linking of operational cases and strategic development.”

“We have had a good experience with them and a very positive response from them.”

8.6 Perceived quality of the project

There is among stakeholders a real sense of the quality of service the BME case advocacy service provides and many refer to the personal qualities of both the Advocacy Centre Manager and the project Coordinator in achieving that. The comments from both local stakeholders and the clients of the service provide evidence of the high esteem in which the staff and the project is held.

Local stakeholders' comments

“Spoke to Yvonne asking for a “talk” with a client to start off focus group discussions. Jacqui rang back almost immediately to check out the circumstances. Great care is taken around the safety of the client and them being in charge of what was said.”

“Yvonne has done a lot of community development work and works holistically with people. She is passionate, enthusiastic and hardworking.”

“You have to have confidence in people you refer on to or it can damage your reputation.”

“The way the project works, it works well.”

“Jacqui has managed the service well and is able to move things on.”

“The advocacy centre has friendly, helpful staff who want to support the workers emotionally and with information and training.”

“Yvonne listens and has a very good attitude with people, she is gentle with them.”

“Service works well and people who have been given the number have been asked if they got what they wanted.”

“the strengths of the project are that it provides a good service for people who need help.”

“Offer a fantastic service.”

“Yvonne is really good and her referrals are always appropriate.”

“I have an excellent working relationship with Jacqui and Yvonne.”

“One of the success factors of the project is the commitment of Jacqui and Yvonne.”

“The confidential nature of the service is important.”

“Jacqui and Yvonne are both able to pick up issues for health from their cases.”

“The project is very lucky in both Jacqui and Yvonne – it is so dependent on these key roles.”

“This project has given no problems in terms of receipt of the monitoring report or answering requests for more information. If they need more time they let you know, and not all projects do.”

Clients' comments

“I have recommended this service to friends and they have used it.”

“The fact that it is a professional and can keep confidentiality is important.”

“The project is great.”

“Yvonne listens, is attentive and kind and because she’s a woman she understands me.”

“She always comes with me to the hospital and she calls to check I have taken the tablets. ‘She has become my mother.’”

“I have sent someone to Yvonne already, she has helped her as well.”

“Someone like Yvonne – she is very good. She listens very well and is very kind and helpful.”

“Yvonne is very kind and condescending (but in a positive way not patronising) that in itself is helpful.”

“Yvonne is a person who can not help enough, she tries to do everything to the best quality.”

“All I can say is Yvonne is a nice lady.”

Not one of all of the people interviewed had anything negative to say about the project either from personal experience or through comments from their networks, colleagues or clients. A number did of course identify issues that the project faces and these are covered in a later section of the report.

“I have heard no negative feedback about the project at all.”

“We have not had any negative feedback about them but we do have clients in common.”

“I have received good feedback from the community about the existence of the project.”

9 Discussion

9.1 Understanding of the concept of advocacy

There is an issue in the literature about understanding the concept of advocacy, as well as the distinction between the role of the advocate and the role of the interpreter. This was referred to by five of the stakeholders particularly in the context of a lack of understanding by health care professionals:

“We have tried to get the message to professionals but the health professions do not understand the distinction between interpreters and advocates. Social services understand but some are just resistant to the idea of an advocate.”

“Most health professionals do not understand advocacy and cannot see the difference between advocacy and interpreting.”

“Front end mental health workers are more aware of the needs of clients for interpreters and advocates. Although some staff do not know how to use interpreters and the Interpreting Service has been offering training – the same is needed for advocacy.”

“A lot of health services are not aware of the needs of these people, they need a letter from a GP for an assessment. Not all GP’s know about social services support available and what they need to make decisions, nor about the project although practices in the West End, Cruddas Park and Walker might.”

“Social services staff and solicitors understand what advocacy is but health professionals (GPs and hospitals) do not. It would be good for them to understand so that GPs could refer to the project. Very few NHS staff know about the services available.”

“Some professionals do not understand what the advocate’s role is.”

“Jacqui spoke about advocacy to the Public Health Specialists rotation (we are piloting raising health and race equality issues) – the evaluations showed advocacy was well received and the students felt everyone should have it.”

“Yvonne spoke about a GP who said she couldn’t be present during a conversation with a client.”

“An awareness of advocacy should be part of mental health trust induction.”

Three of the stakeholders referred to a lack of understanding about advocacy among community members and/or a lack of capacity to self advocate:

“Very few people in the community know what advocacy is.”

“Lots of clients are illiterate or elderly and may not develop the skills to self advocate. Some clients have fairly good English but still come for help e.g. one client made ten phone calls but still couldn’t get the issue resolved. I know how to challenge these services”

“Some English speaking partners simply do not have the confidence to speak to professionals.”

One or two of Yvonne’s partners are on the wards but they wouldn’t come to mental health advocacy - they don’t understand what advocacy is.”

The five project clients interviewed were asked the question **“what do you understand by the word advocacy?”** One acknowledged they didn’t know the word or what it meant; one replied tentatively ***“If someone has a question to ask, is it that?”*** The other three used their experience of the project to offer definitions about receiving help either with difficulties or to get services or to refer you to appropriate organisations.

It would seem therefore that there is an opportunity for the project to usefully extend the work they are doing in this aspect of the project. By helping health and social care staff, understand advocacy and its distinction from interpreting and making appropriate referrals for advocacy support across all types of health and social care services. As well as working with community support groups to understand the nature of advocacy and its availability in Newcastle. This would require additional capacity within the project but is clearly needed.

9.2 Advocacy provided within the same cultural context

Another issue referred to in the literature is the desirability of advocates being from the same cultural background as the client. In discussion with stakeholders it became apparent that whilst this might be an ideal in an ideal world, it was not always practically possible because of the diversity within communities as well as between them. From many asylum seekers and refugees there are some within their own communities as an advocate that they would not feel comfortable with because of political, religious or ethnic origin differences.

In order to get a sense of how important this issue is to the clients of the service the clients were asked their views in answer to the question – is the advocate speaking your language important?

“It doesn’t matter that she doesn’t speak the same language.”

“Sometimes we use telephone interpreting. The qualities of the person are more important than the language.”

“No, if she speaks English I can improve my English.”

“If they can speak the community language that is wonderful but I can quite understand that it might not be possible and that it might be necessary to use an interpreter and that is OK.”

“Yes it is most important that the person is from the community because of both the language difficulty and understanding the culture.”

The only person who felt the advocate should be from the same cultural background and community was an older client from the Chinese community who had been in this county for a substantial period of time.

Although this is a very limited sample of clients of the project, it does reflect the findings of the Mind (2006) **“With us in mind: Service user recommendations for advocacy standards in England”** inquiry which reported that the majority of Black and Caribbean service users in their study valued respect and results more highly than cultural identification.

9.3 Management resource available to the project

The original estimate of management time needed to support and develop the project was realistically set at one day a week but the project was asked to cut the bid back significantly. So the management time was reduced to half a day a week but ***“this has caused difficulties because it actually takes up a lot of time.”***

The project has benefited throughout its life from a greater level of management time than has been paid for. It has been necessary for the Advocacy Manager to commit between two days a week to this project although the funding supports only half a day. In other words the other advocacy services and Newcastle CVS are subsidising the BME case advocacy project. During the past year the funding available for interpreting costs was over budget at one stage and Newcastle CVS provided £7, 000 from its own resources to allow the work to continue to meet the needs of the projects clients. If the project were to expand in the future it would require more management time than the current two days.

The need for the management support comes from a number of sources, originally it was to do with the co-ordinators relative inexperience of this type of work. The inclusion of failed asylum seekers among the targeted communities has resulted in the coordinator dealing with extremely complex, demanding and emotional cases where they are often the only means of support between a client and destitution and the worker must have access to the appropriate level of supervision and support themselves. To use the

knowledge gained from the individual cases to influence improved service delivery it is necessary for the manager to attend meetings and forums where the opportunity to influence arises. More recently their have been support tasks around the recruitment, selection, training and supervision of bilingual sessional workers.

With two days management time a week actually paid for, two workers and a division in the workload so that one person could run the advocacy project for individual clients, recruiting, training and supervising bilingual advocates and administering that side of the project and the other concentrating on promoting advocacy in general and BME advocacy specifically to health and social care services, offering training not just in what advocacy is and its difference to interpreting but how to make the best use of these complementary resources in the health and social care workplace.

9.4 Issues facing the project raised by local stakeholders:

During the course of discussions with stakeholders they identified a number of issues that they recognised the project faced. Some of these were strategic issues about the survival of the project recognising the risks relating to sustainability of funding and the stretched capacity of the project, and others were operational issues relating to how the project runs.

Strategic risks identified included:

“Sustainability of the project is essential.”

“Capacity is a key issue for the future and the project needs mainstream funding.”

“Yvonne’s role is isolated and the project is under funded.”

“The project is not adequately resourced; the model works but needs a lot of time and management support – more than was expected

“The project is solely dependent on a lone worker to continue to function.”

“the main issue is the capacity to run the service and develop it.”

“Funding uncertainty – coordinator may start to look for another job well before the end of the project”

“With the uncertainty over future funding the worker may want to start looking for a new job.”

“One of the problems of working with failed asylum seekers is that they are a huge consumer of time and people can become dependent.”

“How does the model of the project lend itself to being funded across NT and W and more mainstream linkages to health services?”

Operational issues for the service:

“There is no incentive for advocates to close cases – we need to look at how to manage this.”

“Extending to other languages –there is considerable effort in training and supervising advocates.”

“Recruitment procedures – word of mouth is the main means but it needs to be more open and transparent.”

“Recruitment is a problem because the level of work available is not secure employment.”

“Jacqui’s provider training – accredited training would enhance the professionalism.”

“hard to define boundaries.”

“There are potential tensions around the different models with BME advocacy having paid bilingual workers and mental health advocacy having unpaid volunteer advocates.”

“ there is lots of administration involved in running the project including booking interpreters.”

“We need a better knowledge of the project administrative system – there seems to be a lot of paper work, we record all actions and make a note of all telephone calls made on behalf of a partner.”

“Broaden the knowledge of advocates about different service providers in health and social care and the community and understanding how they work.”

“We also need to know how to develop networking and how to make it more efficient – sharing information and resources.”

10 Conclusions and recommendations

Conclusions:

This is an effective and well run project that delivers the outcomes agreed with its funding body. It has continued to develop during its three year pilot phase and is valued by local stakeholders and clients of the service. It is inadequately funded and operates under great pressure. This is not just related to the level of demand and the intensity of some of the cases but is also related to the pressure on the whole advocacy centre. This has a potential adverse effect on other advocacy services run by the advocacy centre because of the time the manager has to commit to the support and development of this project at the cost of support and development of the other projects. The pressure forces the project to react to circumstances rather than be proactive. Having said that, there have been benefits to the advocacy centre as a whole in having the BME project along side the other services. ***“The project has affected the other advocacy services in terms of increased cultural awareness and sensitivity to BME issues.*** Some of the BME project clients have been referred on to other services within the advocacy centre.

One of the real strengths of this project is the extensive preparatory work that was undertaken prior to producing a bid for funding. This included seeking the views of community members, seeking to establish what services were already provided in Newcastle for BME communities and specifically which related to access to health and social care; exploring different models of provision and engaging with stakeholders about which model would best fit the circumstances in Newcastle. These activities may have taken a considerable time but they provided an excellent foundation for establishing the project once funding was secured. It provides a good model of the bottom up type of needs identification and assessment and positive engagement with relevant stakeholders that is more likely to produce a project that genuinely meets the needs of disadvantaged communities.

Another real strength of the project is the existence of a diverse and engaged “advisory group”. Its membership includes some of the most knowledgeable people in the city about the needs of BME communities in general and asylum seekers and refugees in particular. There are one or two key individuals who have been involved from the beginning and they provide both continuity and experience of the whole development process of the project.

Because of the expertise available within its membership, the advisory group is thus both a resource to the project staff and a resource of the project in that members promote the use of BME advocacy and use case studies gleaned from the project to influence improvement in health and social care provision.

The project has managed to establish and maintain excellent working relationships with both voluntary and community sector organisations that

work with vulnerable communities and health and social care professionals who work directly with the most disadvantaged members of society. These relationships are valued highly by those interviewed and in my view contribute to the projects reputation and standing.

Another example of good practice by the project is the inclusion of a substantial budget for interpreting costs as a core part of the projects expenditure. Any project, public or voluntary and community sector, working with BME communities should include adequate funding for interpretation ensuring independent, accurate information is available to both the client and any other parties providing services to them.

A number of stakeholders have commented on both Jacqui and Yvonne's qualities and they are highly regarded amongst their peers working in this field. To quote one of the stakeholders ***"The project is very lucky in both Jacqui and Yvonne – it is so dependent on these key roles."***

The single greatest risk to the project is the insecure and inadequate funding the project currently receives. There are insufficient resources going into the project to cover the current actual level of work undertaken, let alone to maximise its potential impact. This situation is not untypical and the trend of funding to the voluntary sector which is almost always short term and frequently inadequate to cover the actual costs of the work that goes into the project has caused the Government to seek to develop strategies to try to rectify the matter in terms of the statutory sector commissioning work from the voluntary and community sector.

A significant number of stakeholders are very concerned about the lack of awareness and knowledge about advocacy and interpreting and the difference between them, particularly among health care staff.

Time and resource constraints force choices on the project about what activities to prioritise. There is considerable evidence that the project is delivering positive outcomes to the individuals it provides advocacy for. It has however not had the resources available to maximise its impact on influencing health and social care services to improve their practice to make services more accessible to BME communities.

In terms of the strategic impact of the project, the old proverb comes to mind, *"Give a man a fish and you feed him for a day. Teach a man to fish and you feed him for life."* Whilst the project is very successful at improving quality of life for individuals from BME communities, especially failed asylum seekers, by enabling their access to relevant health and social care services (*feed for a day*), it is not having the same opportunity to enable those services to be far more responsive to those BME community members' needs in the first place (*feed for life*).

The responsibility for reducing inequalities in health and social care provision rests firmly with the commissioners and providers of those services, with a particular responsibility resting with Primary Care Trusts as commissioning bodies and leaders within the health economy. They should be actively working to reduce those inequalities not just by improving their own policies, systems and practices but also by supporting the organisations working to reduce the impact of those inequalities on people. The “**Delivering race equality in mental health strategy**” recommends that primary care trusts (PCTs) and service providers ensure adequate investment in and provision of culturally appropriate independent advocacy. It can be argued that this is no less important in primary care, where GPs act as the gatekeepers to other services.

If the project were to receive additional resources to both recruit an additional worker and be supported with appropriate management time, it should be able to have the same impact on influencing the statutory sector that it has on improving individual’s lives by facilitating their access to health and social care services.

In the longer term it is influencing change within the statutory service practice that will reduce the needs of the BME community members not the assistance of individuals from that community. The current level of funding and resource does not permit these two priorities to have equal energy and commitment put into them. The project does what it can and indeed is very successful at identifying strategic issues from individual experiences. There is however in my opinion great potential to dramatically increase the impact in this aspect of the work with additional resources.

An additional risk consequent on the insecure funding is that the project worker will look for another job before the funding runs out in June 2008. Two of the advisory group referred to this as a particular issue and two others referred to the isolation of the role and the dependency of the project on an effective lone full time worker. This is a significant risk and the consequences would be severe if the worker were to leave the project before funding was secured. The cost and time lag involved in having to recruit and train another worker would totally disrupt the delivery of this service. If the wider pressure on the Advocacy Centre is not reduced there may also be a risk that other advocacy staff may leave.

This is why the first two recommendations are the substantive ones of the securing of long term sustainable funding for the project from the statutory sector and gaining additional capacity in the project to focus on making as much difference to the cultural competence of health and social care services as it is currently making to the lives of project clients.

The remainder of the recommendations are operational suggestions to improve the working of the project.

Recommendations

The first two recommendations are the substantive ones of the securing of long term sustainable funding for the project from the statutory sector and gaining additional capacity in the project to focus on making as much difference to the cultural competence of health and social care services as it is currently making to the lives of project clients.

- 1 Commissioners of health and social care services should recognise the need to secure mainstream sustainable funding for the service – recognising that alternative funding may be necessary in the interim.
- 2 The level of resources within the project should be increased to fund appropriate management time for support and development and an additional worker to enable an equal concentration on influencing change within health and social care practice to make services more culturally sensitive and appropriate for all members of Newcastle’s community.
- 3 Further targeted activity be undertaken to increase client numbers from the Bangladeshi community.
- 4 The project keeps a record of all the cases signposted to other agencies, organisations or groups in order to more accurately reflect the project activity.
- 5 Consideration should be given to undertaking work with project staff to clarify the boundaries of what is meant by “health and social care” in terms of the activities of the project, this should then be discussed with relevant stakeholders.
- 6 A review should be undertaken of the ways achievement of outcomes for individuals are monitored by the project. The Advocacy manager should have a role in independent monitoring, perhaps by selecting a sample of clients from the project for evaluation and interviewing them to understand their perception of the outcomes achieved and the quality of the service.
- 7 A review of project documentation should be undertaken to reduce it to the minimum consistent with running an efficient and effective project including the flexibility of the computer system
- 8 Further work to be undertaken on refining the outcome logic model so that the outcomes listed are within the projects capacity and capability to deliver.

- 9 Further work be undertaken by the advisory group to consider future development of the project, dependent on the outcome of recommendations 1 and 2. (the material generated during the evaluation about possible developments is recorded at appendix 11.5.)

11 Appendices

11.1 List of contributors:

Stakeholders for Newcastle BME advocacy project

- 1 Linda Allen - Newcastle CVS - Case Advocacy Co-ordinator
- 2 Denise Briddon – Service Development Manager, Newcastle Interpreting Service
- 3 Yvonne Cheung – Newcastle CVS - BME Communities Case Advocacy project –co-ordinator
- 4 Susan Donnelly – PCT Nurse lead for asylum seekers and refugees
- 5 Tessa Gray – Rights project
- 6 David Hildreth – Primary care mental health worker
- 7 Carole Howells – Director Newcastle CVS
- 8 Interpreter who works with French speaking clients particularly asylum seekers
- 9 Jacqui Jobson – Newcastle CVS Advocacy Centre Manager
- 10 Shervin Khademe Nori – project bilingual sessional worker
- 11 Elton Kwok Leung So - project bilingual sessional worker
- 12 Ann McNulty – Co-ordinator Health and Race Equality Forum (HAREF)
- 13 Claire Moor – Grants Officer, Big Lottery Fund
- 14 Hakija Stitkovac – Social Worker
- 15 Suzanne Thompson – Delivering race equality in mental health; focussed implementation site project manager
- 16 Mahvash Yazdani-Damavandi – Information and advice worker – Iranian Centre North East
- 17 Paul Veitch - Team manager, Early Intervention in Psychosis Team

Clients interviewed

- Client 1 – Chinese community
- Client 2 – Chinese community
- Client 3 – French speaking African community
- Client 4 – Kurdish community
- Client 5 – Iranian community

Other people contacted

- 1 Cynthia Chui – Chinese mental health advocate, Chinese National Healthy Living centre
- 2 Helen Clarke – IMCA Manager and Director of Kingston Advocacy Group
- 3 Michael McKeown – University of Central Lancashire, Mtetezi
- 4 Alan Wenham – Advocacy project manager, City and Hackney MIND

11.2 List of project documents examined

- HAZ Race area of special action – health advocacy terms of reference
- Report of Advocacy and Interpreting sub-group – August 2001
- Health Advocacy for BME communities – Action Plan
- Documents relating to the Health Advocacy for BME communities workshop held on 17th February 2003 (programme; advocacy case studies; case advocacy models for BME communities; workshop report and workshop evaluation).
- Health Advocacy for BME communities – model of advocacy service (draft 3 – September 2004)
- Community Fund – outline proposal draft – January 2004
- Big Lottery Fund application 10/1/2005
- Final job description – BME Case Advocacy Co-ordinator
- Project Plan for Case Advocacy for BME Communities
- Co-ordinators detailed work plan 20/6/05 – 30/12/05
- Big Lottery agreed project outputs and outcomes and monitoring arrangements
- BME Advocacy Project – End of year report 20/6/05 to 19/6/06
- Notification of changes to your project form – dated 24/7/06
- Paper “Advocacy for all?” by Clarisa Carvallho (Co-ordinator of provision of bi-lingual mental health advocacy in Barking, Dagenham, Redbridge and Havering).
- Notes of meetings of Newcastle HAZ – Advocacy and Interpreting subgroup (18/2/00; 4/5/00; 5/7/00; 19/9/00; 13/11/00; 18/12/00)
- Notes of Health Advocacy BME Meetings (13/9/02; 1/11/02; 13/1/03; 27/2/03; 11/6/03; 22/9/03; 11/11/03; 1/12/03; 12/12/03; 8/1/04; 15/6/04; 7/9/04; 22/10/04; 23/11/04; 13/12/04; 12/4/05; 28/4/05;)
- Advocacy referral process – flowchart and letter (recording of unmet need)
- “Advocacy requests record of unmet need” – form (drafts 1 and 2)
- List of Newcastle organisations “speaking up for individuals” (advocacy).

11.3 List of other reference resources

- 1 W.H. Kellogg Foundation – **Evaluation Handbook**
- 2 Joseph Rowntree Foundation – Findings – **Mental health advocacy for black and minority ethnic users and carers**
- 3 Rukshana Kapasi and Mike Silvera, Silkap Consultants – **A standards framework for delivering effective health and social care advocacy for black and minority ethnic Londoners.**
- 4 Kings Fund working paper December 2004, Baljinder Heer – **Building Bridges for Health – exploring the potential of advocacy in London.**
- 5 British Journal of Social Work (2006) 36; 1209-1225 – Alison Bowes and Duncan Sim – **Advocacy for Black and Minority Ethnic Communities: Understandings and Expectations.**
- 6 **Service level agreement** between the Delivering Race Equality Programme, Department of Health and North east, Yorkshire and Humber region, care Services Improvement Partnership.
- 7 **Delivering Race Equality in Mental Health action plan**
- 8 **Preparing for Independent Mental Health Advocacy** – presentation by Di Barnes to the DH conference “BME advocacy and the Mental health Act” in London, 25th October 2007.
- 9 **Mtetezi developing mental health advocacy with African and Caribbean men** - presentation by Michael McKeown to the DH conference “BME advocacy and the Mental health Act” in London, 25th October 2007.
- 10 Social Care Institute for Excellence, Adults’ Services Knowledge Review 15 - **Mtetezi Developing mental health advocacy with African and Caribbean men**
- 11 Clarisa Carvallho (Co-ordinator of provision of bi-lingual mental health advocacy in Barking, Dagenham, Redbridge and Havering). Paper **“Advocacy for all?”**
- 12 Michaela Fay - **Asylum seekers and refugees in Newcastle upon Tyne – an overview of Mental Health Service needs, provision, and pathways**
- 13 Provider Care and Health Magazine, September 14-20 2004, article **“Lost in Translation”**.

14 KAG Advocacy – **Annual Report 2005/2006**

15 Graham Stacey and Angela Brown “**Access to Health Services for Black and Minority Ethnic Communities, Refugees and Asylum Seekers – Feasibility study for Community Action of Health, West**”. October 2003

16 Julian Prior “**Destitute and Desperate: A report on the numbers of “failed” asylum seekers in Newcastle upon Tyne and the services available to them.**” Commissioned by Open Door (North East) – April 2006.

17 Mind (2006) “**With us in mind: Service user recommendations for advocacy standards in England**”

11.4 BME Case Advocacy Project Pilot - Outcome Logic Model draft 3

For Whom	Assumptions	Process	Outcomes	Impact
<p>Currently : People who have limited English language and understanding of health and social care services and need help in accessing those services from the following 4 communities and languages -</p> <ul style="list-style-type: none"> French speaking African Community Iranian community Chinese Community Bangladeshi Community <p>including - asylum seekers and refugees</p>	<p>About potential partners: People from BME communities are often disadvantaged when accessing health and social care</p> <p>BME individuals feel that a service is more responsive to them when it is specific to their needs e.g. bilingual workers</p> <p>BME communities have equal access to services and that interpreters are free of charge or that it is the persons responsibility to access interpreting services</p> <p>About advocacy – Advocacy is free to the people using it</p>	<p>Working with advocacy partners: Case advocacy is provided by bilingual advocates and through using interpreters to advocate and support people to use health and social care services.</p> <p>Working with others: Network with public sector; voluntary agencies, communities etc - using systems already in place, develop links with others i.e. PALS; CAB etc</p> <p>Provide awareness sessions for communities; organisations; interpreters etc</p> <p>Issues are identified re health and social care and worked through and resolved as far as they can be taken in line with person’s choice.</p>	<p>For individuals: Having a voice and empowerment Individuals feel that with advocacy they have been empowered to be able to put forward their case and have had their views heard</p> <p>Individuals able to self advocate in some circumstances</p> <p>BME individuals have had their rights upheld</p> <p>People having informed choices</p> <p>BME/asylum seekers/ refugee communities have a stronger voice in Health and Social care system, having their confidence increased would empower them to ask for what they need.</p> <p>Information Promote equal access to all information including information on rights and choices</p>	<p>People from Black and Minority Ethnic Communities in Newcastle have access to health and social care services that are appropriate and responsive to their needs</p>

For Whom	Assumptions	Process	Outcomes	Impact
	<p>Advocacy is about empowering people – enabling choices</p>	<p>Negotiation with services and raise issues in Advisory group or other Race and Equality groups</p> <p>Managing the project: Set up BME Case Advocacy Advisory Group to give advice to the project.</p> <p>Provide good accessible information about and promotion of the project</p> <p>Develop a realistic monitoring method which enables recording outcomes of advocacy as well as standards of bilingual advocates work</p>	<p>Access Promote equal access to appropriate and responsive services</p> <p>Quicker access to support and advice and better standards of care</p> <p>Quality of life BME individuals having the quality of their life improved.</p> <p>For services and professionals: Awareness of needs: Service providers become more aware of the needs of BME communities in order to provide services to meet those needs</p> <p>Policies on service provision could consider the difficulties that individuals face. Asylum seekers and refugees are not discriminated against in the provision of services.</p>	

For Whom	Assumptions	Process	Outcomes	Impact
			<p>Health service providers would cover all the needs of the people who are using their services – so health service users would have all the knowledge about where and how they will get help within the services</p> <p>Responding to needs: Statutory agency staff have self awareness of the assumptions made by the dominant cultural ethnic group and make appropriate changes to their practice i.e.</p> <ul style="list-style-type: none"> • ensuring equal access • sensitive to all cultures • promote equal opportunity and diversity <p>Identifying gaps in health services. Service providers would try to fill the gaps, to make their services easy to use and available for all service users</p> <p>Influencing change: The project is able to challenge service providers which undermine equality and diversities</p>	

For Whom	Assumptions	Process	Outcomes	Impact
			<p>Members of project advisory group to take issues to relevant organisations to make changes</p> <p>Community organisations and professionals are able to refer to case advocacy for complex cases and independent support</p> <p>For advocacy service and advocates: Bilingual advocates are well recognised as a professional. The BME Case Advocacy project maintains its profile</p> <p>Bilingual advocates are well trained and their standards should be maintained according to the changes of structure of the project or systems or policies around health/ immigration/social settings</p>	

11.5 BME Case Advocacy Project Pilot – Developments proposed by Advisory Group members – 15th November 2007

Possible Futures for the Pilot Project (brainstormed list)

- Mainstream funding – have workers attached to teams and services. The project should become a mainstream part of the NHS – this is to help and support the health service users.
- Open up to more BME communities, (Newcastle citywide service) working with groups to support them with similar issues. Expanding BME communities from the 4 that are currently served
- BME advocacy in Newcastle to include all BME groups – outreach into a number of communities and open access to the rest.
- To provide advocacy services for all communities covering not only Newcastle but also surrounding areas of Gateshead, North Tyneside, and Northumberland etc.
- BME advocacy across the region
- Specific Mental Health BME Advocacy across regional? ; North of Tyne? ; Tyne and Wear.
- The project is not only restricted to working with mental health clients.
- BME advocacy to stay as it is to continue to consolidate

During discussion there was no support from the advisory group to expanding the scope of the project beyond health and social care issues to any advocacy issue raised by those from BME communities.

Process developments for the pilot project

Access

- More bilingual advocates to support more cases as referrals grow.
- Quicker access through different method i.e. referral; email; website; telephone etc
- Access to service - open session – walk in service
- Out of hours service

- Communication about service availability – everyone knows about it
- More famous than before: who they are and what they can do.
- More clients with different backgrounds
- Relevant cases

Partnership working

- To work with other agencies to provide drop in sessions in order to identify clients in different areas especially those hard to reach clients.
- Be able to organise more community events with groups to maintain trust and respect from community groups.

Support for bilingual advocates

- Bilingual advocates should have completed an accredited training course which ensures professionalism of the service.
- More time /availability to support bilingual advocates. Provide regular training and social gathering between advocates.

Performance management

- Monitoring system should improve to measure specific outcomes such as the impact of advocacy on people's life.
- ? evaluate 4 communities
- ? areas of health and social care not working in

New members of the advisory group would like to see for the future?

I'd like to see access for all BME communities and support for health, social care and well being issues

I'd like to see bilingual advocacy for all communities being integrated within statutory organisations and supported by voluntary organisations

I would like to see BME Advocacy service available for all when needed. I would like to see BME Advocacy service accessed by statutory and voluntary sector providers – well publicised, resourced and with ease of access

I'd like to see a link between issues raised and service improvements and contracts set up between health and social care and voluntary sector to buy in the service

An advocacy service for all BME communities and refugees within Tyne and Wear? Or Newcastle, North Tyneside, and Northumberland?

Developments proposed by stakeholders interviewed:

“Possible bid for “independent mental health advocates.”

“It would be good if the service could be available to other communities, perhaps Polish or newer communities.”

“If there to be an expansion of the project there is a significant requirement for Czechs; Slovaks and Polish community members in the west end and on a Newcastle wide basis the Turkish community.”

“If the project develops it should undertake more intensive work (number of hours /clients) in the language groups it already works with to build a bank of expertise in the communities around health and social care. It could expand by introducing another language group. If it were to expand its scope then it could cover education but that is probably another project.”

“There is potential for a full time worker for each community. Service is publicised to the women’s group but could be much wider to reach more of the community.”

“In terms of developments advocacy having a service to help people fill in forms related to health and social care would be good, e.g. disability living allowance.”

“If the service develops it should go for more languages but expansion would need to be staged. The health and social care remit is very wide but needs very clear parameters about what is covered.”

“Recognition of the time needed for complex cases and the development of case studies that can be used for strategic development. More management time.”

“Advocacy has the networks (especially through the Interpreting Service) to identify what communities might need to be the next focus of activity.”

11.6 Assessment of achievement of outcomes from the “outcome logic model”

Outcomes identified by advisory group in project outcome logic model	Evaluation evidence of achievement of outcomes
<p>For individuals: Having a voice and empowerment Individuals feel that with advocacy they have been empowered to be able to put forward their case and have had their views heard</p> <p>Individuals able to self advocate in some circumstances</p> <p>BME individuals have had their rights upheld</p> <p>People having informed choices</p> <p>BME/asylum seekers/ refugee communities have a stronger voice in Health and Social care system, having their confidence increased would empower them to ask for what they need.</p> <p>Information Promote equal access to all information including information on rights and choices</p> <p>Access Promote equal access to appropriate and responsive services</p> <p>Quicker access to support and advice and better standards of care</p> <p>Quality of life BME individuals having the quality of their life improved.</p> <p>For services and professionals: Awareness of needs: Service providers become more aware of the needs of BME communities in order to provide services to meet those needs</p>	<p>Specific feedback from one client and implied by other clients</p> <p>One specific example given and others implied</p> <p>Several examples given</p> <p>Implied by clients and others</p> <p>Examples given of this happening through the work of the advisory group</p> <p>Examples given by clients and others</p> <p>Examples given by clients and others</p> <p>Some limited example in services that deal with the most disadvantaged community members</p>

<p>Policies on service provision could consider the difficulties that individuals face. Asylum seekers and refugees are not discriminated against in the provision of services.</p> <p>Health service providers would cover all the needs of the people who are using their services – so health service users would have all the knowledge about where and how they will get help within the services</p> <p>Responding to needs: Statutory agency staff have self awareness of the assumptions made by the dominant cultural ethnic group and make appropriate changes to their practice i.e.</p> <ul style="list-style-type: none"> • ensuring equal access • sensitive to all cultures • promote equal opportunity and diversity <p>Identifying gaps in health services. Service providers would try to fill the gaps, to make their services easy to use and available for all service users</p> <p>Influencing change: The project is able to challenge service providers which undermine equality and diversities</p> <p>Members of project advisory group to take issues to relevant organisations to make changes</p> <p>Community organisations and professionals are able to refer to case advocacy for complex cases and independent support</p> <p>For advocacy service and advocates: Bilingual advocates are well recognised as a professional. The BME Case Advocacy project maintains its profile</p> <p>Bilingual advocates are well trained and their standards should be maintained according to the changes of structure of the project or systems or policies around health/immigration/social settings</p>	<p>Example of project identifying service gap</p> <p>Specific examples of challenges to services given and others implied</p> <p>Specific examples given of this happening</p> <p>Specific examples of this provided</p>
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11.7 Assessment of achievement of outputs and outcomes required by the Big Lottery Fund

Outputs and Outcomes required by the Big Lottery Fund	Evaluation evidence of achievement of outcomes
<p>Outputs</p> <p>Provide at least 20 advocacy cases in year 1 and 40 in years 2 and 3</p> <p>During advocacy cases at least 100 people will be supported in gaining information about their circumstances and learn how to use this.</p> <p>Training and awareness raising sessions will be provided – these were about advocacy and to be provided to both BME communities and health and social care professionals</p> <p>Outcomes for individuals:</p> <p>Individuals from BME communities will have better access to health and social care services.</p> <p>Individuals from BME communities will improve their self confidence and gain increased knowledge about their rights</p>	<p>This target has been exceeded with 117 clients helped by the project up to 19th December 2007.</p> <p>From interviews with five clients it was apparent that they had gained information about their circumstances, services available and other sources of help</p> <p>Copies of training materials in different target community languages were available as well as leaflets promoting the advocacy service. Stakeholders confirmed that awareness sessions had been offered and provided both to BME communities and health and social care professionals</p> <p>Feedback directly from clients and from stakeholders who had also received feedback from mutual clients about their access to health and social care services as a direct result of project activity.</p> <p>Feedback from clients and stakeholders about specific examples of clients gaining in self confidence and knowledge of rights</p>

For health and social care professionals

Health and social care professionals will gain a better understanding of non English speaker's needs.

Feedback from stakeholders reflected that the project is effective in increasing health and social care professionals understanding of non English speakers. It is this aspect of the project that I feel has the most potential for development.

11.8 Evaluation questions suggested by stakeholders:

“Evaluative description of the impact on commissioning. Go back to the targeted communities and see if they are aware of the project.”

“Need to speak to those in health who have worked with the advocacy project – impact on them and how they see the future of the project.”

“Talk to someone in health and social care who should be using interpreters and advocates but isn’t.”

“Crisis team have a set of questions to do with whether it is a crisis but they don’t translate for BME communities.”

“Measures for success could include surveys with health and social care staff – do they know about the service and its systems. Are they providing information to patients in appropriate formats?”

“Need to think about the fit of the BME project within the advocacy service – look at who funds the main advocacy service and what for. How has this project impacted on advocacy services provided for BME community members?”

“Should this project be included as part of an overall package of advocacy services or split off to stand alone as a separate service?”

“The project covers four languages but the worker speaker’s only one of them – it might be worth looking at the balance of support for the communities.”

“Talking to the funder and evaluating their approach.”

Newcastle Advocacy Centre provides:

- * Citizen advocacy for vulnerable adults in Newcastle.
- * Case advocacy for people with mental health problems.
- * Case advocacy for people from Black & Minority Ethnic Communities.
- * Support to Advocacy Network Newcastle (ANN) which is open to individuals and groups with an interest in advocacy.

We are often looking for volunteer advocates.

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