

**Delivering Race Equality: Improving BME Outcomes in
Education and Employment. A London survey of Early Intervention in Psychosis
Teams and links with the Further Education system, June 2008**

Executive Summary

Convergence between two major Policy initiatives in the Department of Health, and National Institute of Adult Continuing Education/Learning Skills Council, afforded the opportunity for a strategic partnership project to be carried out in the summer of 2008. This was led by Dr Annie Lau from the DRE National Team, and Victoria Sturdy, London Regional Lead at NIACE/LSC. "Improving services to people with mental health difficulties" (LSC, 2006) sought to engage learners with mental health disabilities, and the Delivering Race Equality Action Plan (DoH, 2005) focused on improvements in service delivery, with attention to the recovery needs of BME (Black and Minority Ethnic) service users. Progress in both areas, with engagement of clinicians, was slow in 2006. It was suggested that the Early Intervention in Psychosis teams, with new staff resources and funding available to mental health Trusts, and a new remit to provide community mental health services along lines of social inclusion and recovery, could be a worthwhile focus for development of the Health/Education interface. This would also bring the DRE Action Plan, and the needs of BME service users, into the mainstream of service improvement initiatives in both Health and Education sectors.

A London wide survey of Early Intervention in Psychosis teams was then carried out between June and September 2008, sponsored by the London Development Centre, with a concurrent survey of Further Education colleges in the London area. Participating teams were asked to share issues, barriers to partnership development between further education colleges and mental health teams, and to give examples of good practice and workable strategies. Engagement of BME service users in training and education was also monitored by this survey. A subsequent questionnaire also asked for more detailed breakdown of demographics including ethnicity, and for inclusion of figures for engagement in work and employment. Learning was disseminated via Locality learning events organised by the National Institute of Adult Continuing Education, with support from Health providers and commissioners. The majority of EIP teams in London participated, and the Comments from the Teams identified workable strategies that could be disseminated. The results showed that where EIP teams had developed mature relationships with learning providers, often with dedicated Education, or Employer liaison staff, high proportions of the EIP caseload were likely to be supported to engage in education or training. This would also show BME rates of engagement proportionate to BME numbers in the local communities. Further Education Colleges with high levels of uptake by service users were those who had engaged thoughtfully with mental health teams, were flexible in making adjustments to service user/learner needs, and also received good staff support.

Policy context

One of the key objectives of the Delivering Race Equality Action Plan, 2005, is to improve BME service users' access, and experience of services, with improved outcomes. Outcome indicators should include a recovery and social inclusion focus, with higher numbers of BME service users being able to access training, education and work. This would also be in line with the National Social Inclusion Strategy, and it is known that Employment outcomes are influenced by Education outcomes (National Social Inclusion Programme, CSIP, 2006, Social Inclusion Task Force, 2006).

Participation in learning and skills:

- promotes social integration and inclusion,
- helps to break down the fear and ignorance that prevails about people with mental health difficulties,
- builds confidence and self esteem in individuals,
- is a crucial part of the recovery journey, and
- enables individuals to develop skills and qualifications that improve employment opportunities and prospects.

Early Intervention in Psychosis teams (EIP) were set up under the NSF to reduce the duration of untreated psychosis, known to be about two to three years in traditional mental health services. Early intervention, within this critical period of three years, enhances client engagement with services, and improves prospects of recovery (Reading & Birchwood, 2005). EIP teams are funded with staffing resources to promote social inclusion and recovery for its clients, beyond medication compliance alone. EIP practice routinely involves families in treatment and care plans. Service users should be introduced to a range of opportunities in leisure, training, and meaningful activities as soon as the condition is sufficiently stable, and they are out of crisis. Access to education, and training for re-employment, if undertaken during early stages of the client's care pathway, would prove a challenge to previous negative expectations of service users, as well as staff. Positive outcomes would also serve to combat negative public expectations, and stigma in communities.

LSC/NIACE/NIMHE Partnership Programme

In 2006 LSC (Learning and Skills Council) published its strategy 'Improving services to people with mental health difficulties', signalling a clear commitment to this group of learners. Specific aims were to build capacity of the further education system, boost demand for learning amongst people with mental health difficulties, ensure quality of the learning experience, and raise achievement levels among learners with mental health difficulties (James, 2005). Learning for Living and Work, a strategy for learners with learning difficulties and/or disabilities including mental health difficulties, also reflects the broader LSC agenda to improve the life chances and employment prospects of all learners (LSC, 2008).

The partnership team at NIACE works at national and regional levels to promote access to, and success in, learning and skills, so that people who have mental health difficulties can lead active and fulfilling lives as members of their communities and in employment, in ways that sustain positive mental well being. Nine regional officers support the work of Networks with a membership of 1500 drawn from practitioners in Education, Health, Mental Health Services, Vocational Services, Employment Museums Libraries and Archives, Community and Voluntary Sector groups.

The mental health strategy, LSC, is currently being reviewed. Copies of the strategy refresh are now available, and copies may be downloaded at

http://readingroom.lsc.gov.uk/lsc/National/Mental_Health_strategy_refresh.pdf

Responses are welcomed from a wide variety of sectors. The consultation period runs from 29 September 2008 to 19 September 2009. The final strategy will be launched in February 2009.

Creating inclusive learning opportunities – promoting access to learning and skills for people from black and minority ethnic communities who experience mental health difficulties (Dutton, 2006).

This short NIACE pilot project aimed to explore the links between adult learning, mental health and race equality. Three further education providers in London were tasked with the objective of providing pathways to culturally sensitive learning provision. They were supported to consult with service user groups to identify existing barriers to learning; to develop inclusive and culturally appropriate learning opportunities and support pathways that enable black and minority ethnic service users to access learning; to develop new partnerships and capacity building for effective collaboration between education and local community organisations and mental health user groups.

The **College of North East London** identified a lack of support for asylum seekers and refugees with mental health difficulties, in spite of the large number of asylum seekers and refugees in the local area. A mental health forum was set up and facilitated by a Turkish speaking learner. Group members decided on the topics and areas of interest to be discussed, for example, immigration, stigma and discrimination, citizenship, and strategies to manage mental health distress in learning environments. Members supported each other to

take up learning opportunities. They also discussed wider personal issues that affect learning participation, mental health, and well being. Similarly, **Mindlift, from Community Education Lewisham**, used new ways of outreach to identify adults from the local, settled Turkish community who wanted to participate in learning. This included starting a Turkish foil embossing course in a local community centre, a cultural medium familiar to the local Turkish community. Learners from the initial course enrolled others, and made links with the ESOL department and Mindlift.

Lambeth College worked with Black African-Caribbean men who were mental health service users attending resource centres, and not engaged in learning. Consultation with the learners led to formation of a music group which was to be self directed in order to be sustainable. Barriers were lowered when the group began talking about music making, and learners developed their skills. Over time, they worked as a team, became more confident, and ultimately performed at events. Some of the men went on to attend music and other courses at the College.

Key findings from this pilot project were;

- Learning and skills Providers have an opportunity to boost demand for learning, through widening participation by outreach to under-represented groups – as demonstrated by the three pilot projects in the report.
- Provision needs to be culturally sensitive and targeted.
- People from black and minority ethnic communities, particularly those for whom English is not their spoken language, who experience mental health problems, are severely disadvantaged from gaining skills and entering the workforce.

Both DoH and DfES have cited the need for more research and development on the barriers that adults from black and minority ethnic groups experience in participating in learning, especially those with mental health difficulties (Cabinet Office, 2003). Data from the 2004 UK Labour Force Survey was analysed in a NIACE briefing on participation in adult learning by black and ethnic minority ethnic communities (Aldridge et al, 2006). 63% of adults from black and ethnic minority groups participate in learning, though this figure masks differences between groups. The national average participation rate is 64%, Black African 77%, mixed ethnic origin 76%, Pakistani 48%, Bangladeshi 40%. Black Caribbean and Indian respondents participate at a level similar to the adult population as a whole, ie 64%.

The Social Exclusion Unit highlights how lack of access to learning and skills has wider consequences for families, communities and the economic wellbeing, affecting large numbers of people in particular areas of London. A consultation event was also held in 2006 with Refugee Action, Vietnamese Mental Health Association, and Chinese Mental Health Association, to identify different levels of learning need, and perceived barriers to access, from the perspectives of the different groups. Poor competence in English language and lack of access to ESOL courses was a major factor, also high eligibility criteria thresholds in further education colleges which deter people from putting in applications.

The above conclusions have informed subsequent developmental activities in 2008, and the need for focused data collection on the needs of different groups.

The London study, EIP Teams/Further Education system interface

(1) Aims

1. To assess what proportion of people receiving services from Early Intervention in Psychosis (EIP) Teams in London are currently receiving education, or training, and work.
2. To assess how clients from ethnic minorities compare with white British clients in terms of proportion in education, training and work in EIP Teams.
3. To obtain staff views regarding the barriers their clients face in attending courses or obtaining employment.
4. To obtain 'good news stories' from staff members where clients have successfully attended courses, or obtained employment.

5. To find out about successful partnerships that EIP staff have formed with Education providers and Employers and how these have been achieved.

(2) Methods

1. Twenty five EIP teams based in London were asked to take part in the project, and sent questionnaires by the EIP Network Co-ordinator, London Development Centre, to complete.
2. Each team was asked to provide basic quantitative data about their Team Active Caseload on the 21st June 2008. This included the total number of clients on their caseload, the total number of BME clients on their caseload, the total number of clients in training or education (including school, university and college), and the total number of BME clients in training or education.
3. Each team was also given a written qualitative Comments Questionnaire with 3 questions:
“Can you tell us about any issues or barriers your clients have experienced regarding attending courses or obtaining employment?”
“Can you give us ‘good news’ stories about clients who are successfully attending courses, or who have obtained employment?”
“Can you share the learning as to how you have achieved successful partnerships with work or education providers?”
4. A subsequent follow-up Questionnaire was sent to each Team requesting numbers for the total number of clients in volunteer and paid employment.
5. Further details regarding the BME clients in education and employment were also requested, which included client ethnicity, gender and age.

(3) Results

There was good engagement of EIP teams across London with the Survey. Twenty four out of twenty five teams responded to the Questionnaires. The majority of EIP teams also sent in narratives around successful engagement of their clients in education and training, and their experience with barriers to effective partnership working, and some shared their solutions. These accounts came across as authentic, and reflected team aspirations to improve services.

(1) Quantitative Data

24 of the 25 EIP Teams in London provided data regarding their active caseload on 21st June 2008 (Appendix, Table 1.). The combined total active caseload of the 24 teams on this date was 2177 clients. Of these clients 66.3% were BME clients. 536 clients (24.6%) on the total caseload were in education or training. Overall, 22.5% of White British clients were in training or education, 24.5% of BME clients were in training or education.

8 of the EIP Teams also provided further data regarding their clients in education and work. 69% of total caseload were BME. Within these teams, 23% of all clients were in education or training, and 22.1% of all clients were in employment, giving 45.1 % of total clients engaged in education or training, or work activities. When considering BME clients only, the results showed slightly higher percentages for BME (28.4% in education or training, 25.1% in employment) (Appendix, Table 2). The mean age, all clients, was 24.3, of which 60.6% were male, 39.4% were female. 65.5 % were Black African, Black Caribbean or Mixed White & Black ethnicity. 21.1 % were of South Asian ethnicity (Appendix, Table 3.).

(2) Qualitative Data (Appendix, Team Comments)

- **Barriers to attending courses and achieving employment**

Barriers identified included factors relating to the client's illness. A frequently mentioned factor was the client's lack of motivation. This could result in clients missing appointments with vocational services. “Keeping motivation and enthusiasm going is a challenge as clients show fluctuating motivation”. Poor self-esteem can also be a barrier, sometimes preventing clients from giving a good impression at job interviews. Mental health instability was also reported, which could be compounded by poor compliance with medication, or side effects of medication e.g. lethargy. Clients struggled with peer integration and some had difficulty

accessing courses due to anxieties about travelling alone, and a lack of transport being available. Substance misuse was also identified as hindering engagement.

Social factors were also described as posing barriers, for example, around financial problems. "We have a proportion of clients who have come to the UK on a student visa and have consequently become unwell. It is often difficult for these individuals as they have often exhausted their financial reserves and can no longer afford the educational fees required for their status".

The 'Benefits trap' was also mentioned by a number of teams. The client's work status has an impact on housing benefit, council tax benefit and their ability to access supported accommodation. They had experience of entry into full-time employment resulting in, "clients moving back to family home or reliance on family to subsidise income". Childcare was also a potential problem. Clients who are refugees and asylum seekers often did not have the necessary paperwork, e.g. certificates from previous studies, or recourse to public funds.

Lack of previous educational qualifications and previous experiences of "failure" were mentioned by a number of teams, as well as language and literacy. A specific example follows; "Two Bengali clients would have liked to access Asian Women's Project make up courses, but English is a requirement and they do not speak English". Some BME clients were also reported to experience loneliness and isolation in the dominant white culture.

Tower Hamlets EIP team had 85.9% of their caseload consisting of BME clients, of which 69% was of Bangladeshi origin. They reported finding that Bangladeshi women in their sample, mainly from rural backgrounds and socially deprived circumstances, "do not access education, training and work, due to cultural gender-based issues; women attend clinic sessions accompanied by male relatives". None of the other London EIP teams raised cultural factors as contributing to BME barriers to work, or education.

Concerns regarding the stigma of mental illness were raised, and the issue of whether to declare a history of mental illness to potential employers. The experience of one client was reported who accounted for a gap in his CV by telling interviewers he had been in hospital. He subsequently felt he was not given a fair chance, due to having disclosed he had mental health problems.

Frustration was mentioned by one team who experienced some college staff as having unreasonably high expectations and standards for their clients. Abilities of their clients were measured "against the abilities of those not suffering from psychosis/mental illness". Another team expressed a converse view, where they had found expectations could be too low, and both family and staff were anxious to encourage their clients to engage in work and/or education. They felt it was important to, "challenge staff to ask the work question, and to inform clients of all opportunities".

- **What's working, and 'Good News' stories**

It was encouraging to find that many EIP teams are successfully developing active partnerships with locality Further Education (FE) providers and employers. Having a dedicated vocational worker who does not have Care Coordinating responsibilities was recurrently reported as a crucial factor to facilitate this. Barking & Dagenham are working with their local FE provider on a "Education and Career Development Plan", which will incorporate a Wellness Recovery Action Plan (WRAP). They are planning to set up a group initially focusing on "orientation to, and normalization of the FE college environment, study skills, anxiety management, as well as supporting the client to access the appropriate learning support".

Active outreach to education providers, employers, volunteer agencies, and Job Centre Plus was found to be helpful. Inviting FE providers to a team meeting, or phone contact, was repeatedly reported to be beneficial in building links. Most teams stated they found mental health coordinators, based at Colleges, very willing to be involved. Lewisham reported that

South London and Maudsley Mental Health Trust have a contract to deliver supervision to the Mental Health Co-ordinator at Lewisham College.

Camden & Islington Team's in-house vocational service (Vibe) have formed a successful partnership with The Roundhouse in Camden which provide a number of short courses in a wide range of creative subjects including dance, drama and music. Kensington, Chelsea & Westminster EIP team reported that a key part of the vocational worker's role has been challenging employers who present obstacles, "particularly around disability legislation". Also important has been providing ongoing support for employers and clients in the workplace to enable clients to sustain jobs.

Hackney College reported the benefit of having a mental health liaison person, funded by Health but based in Hackney College, very useful for keeping clients on track in the learning environment. Lambeth College benefited from a eighteen month outreach programme, of mental health awareness training, in 2000- 2002. As confidence in the partnership arrangements increased, student attendance increased by 400%, there was a 300% increase in students moving to mainstream courses, and courses on offer increased from 4 to 22, an increase of 400%. Service users were employed as classroom assistants and tutors. The point made was that these relationships had to be actively developed, with good leadership across the Health /Education divide.

(4) DISCUSSION

DRE perspective

Results from the Count Me In national census findings of 2005, 2006 and 2007 have shown more adverse care pathways for BME service users, and entry into inpatient services in secondary care. Surveys of patient care pathways, and access to primary care, and community mental health teams have not yet taken place. The London Survey of EIP teams, using data submitted by the teams on the basis of a one day audit of active caseload, seems to show that Early Intervention Teams across London are reaching BME groups, with 66% of the total caseload being BME (as per DRE definition). In various forums where this work has been presented, staff expressed surprise at the high numbers of BME uptake in EIP services. This also raises the question of what is happening in other Community teams, eg Crisis Resolution/Home Treatment, Assertive Outreach, generic Community Mental Health Teams, and whether similarly high levels of BME engagement are also achieved; and if not, then why not. This would need to happen in order for BME client groups to achieve more equitable access to good patient care pathways, and to achieve the vision set out in the Darzi Next Stage Review (DoH, 2008)

It would also appear that BME clients in EIP teams have at least equal access to training and education, and where teams achieve high levels of client engagement in education, training and work, BME uptake and engagement levels also appear to be also high, reflecting community proportions. So mental health providers in London may be "doing some things right" (personal communication, Professor Chris Hollis) in enabling the "DRE dream" to take shape; in particular, improving service experience and recovery outcomes for BME mental health users in EIP teams.

Partnership working

The survey shows the importance of partnership working across both Health and Education domains, in helping people with mental health difficulties to achieve their potential. This is particularly crucial now as Machinery of Government changes transfer responsibility for this group of learners to other agencies after the LSC is disbanded in 2010.

Links and collaboration between local authority agencies, mental health services and learning providers need to be in place so that good practice is continued, shared and that people at deeper levels of disadvantage are not forgotten. The LSC/NIACE/NIMHE Programme showcases examples of partnership working in each Region through the Annual National Conference, Network Meetings, Newsletter and Moodle/Website. One such example comes

from Hackney Community College. Here a dedicated mental health liaison worker is funded by East London Foundation Trust, and works within the College to support learners and staff, also does outreach work with inpatients in Homerton Hospital. This has led to more learners accessing education.

Many learning providers have well established links with Mental Health Trusts, Community Mental Health Teams, Child and Adolescent Mental Health teams. The Early Intervention in Psychosis Teams may not have such well established links in some Boroughs, and the London Survey provides evidence that this is the case.

Good provision that is flexible and meets needs of learners makes a big difference. This often depends on dedicated staff with motivation and good local contacts. Some learning providers have a dedicated Mental Health liaison officer who is able to co-ordinate and smooth the transition from Mental Health Services to College for learners. The London survey showed that not all learning providers respond well to enquiries about support for learners with mental health difficulties, and some are concerned about risks posed by the presence of service users with serious mental illness. The example from Hackney College may be a way forward. They piloted sharing the service user's Advance Directives with the college, with support from the mental health team, with clearly agreed steps around mitigating and managing risk.

There are also gaps in awareness of the current offer by LSC, for example, to Modern Apprenticeships – whereas there is now an LSC Apprenticeship scheme that is more inclusive.

Language difficulties, isolation and loneliness reflect social exclusion and access to learning and skills provision. BME learners are also experiencing increasing difficulties in finding ESOL classes, due to changes in funding. In Tower Hamlets, NIACE has just engaged a project coordinator who will lead a team focusing on engaging Bangladeshi women. Strategies to be used will include community based culturally appropriate gender based activities, similar to the successful Lewisham exercise.

Importance of dedicated education and employment liaison staff

Comments from EIP Teams who report good liaison relationships with learning providers, or employment providers, stress repeatedly that having liaison staff on their teams to actively facilitate development of good relationships across the organisational interfaces was essential to sustaining the client's initial engagement with learning or work. It was also important that these staff should not be burdened with Care Coordinator responsibilities as this would be too distracting, and divert energy from liaison tasks.

Recommendations/Next steps

(1) It is planned to reaudit figures in 18 months, to assess effectiveness of developing partnerships, and movement from current baseline levels of engagement. In London there could be a link to MIDATA for ongoing monitoring, under the auspices of the London Early Intervention Team network, to embed in their programme of ongoing development.

(2) Mental health Trusts and Locality Learning providers in London should continue to invest in joint work, and expand areas of cooperation.

(3) Interest has been expressed by the Royal College of Psychiatry in supporting a spread of the Project out of London to cover key urban areas, and this could link to the existing LSC Regional leads and networks.

Current initiatives include;

- A briefing sheet outlining all the LSC, DWP pathways available for learners with mental health difficulties is made available for practitioners working in Early Intervention teams

- Possible reciprocal training sessions between EI Teams and their local FE providers on recognition of early detection of psychosis; courses funding available locally
- NIACE is leading an ESOL based project targeted at women in London, 'A Woman's Place', which considers mental health support needs of this group of learners
- Guidelines for FE providers on mental health/learning/race equalities competencies are being developed and critically appraised by local groups, as part of the wider research into learning styles.
- LSC/NIACE/NIMHE Network meeting on 27/1/09 has an EIP focus, and link to local FE providers. The intention is to showcase work of the Partnership of Headspace and Highbury College in Portsmouth, who have developed a joint curriculum for young people, 'Back on Track', including results of first year of the pilot, and presentation from two learners now accessing mainstream courses.

(4) PCT Commissioners should invest in dedicated learning and employment liaison posts in all EIP teams, so that the recovery needs of all mental health service users can be further progressed. The evidence shows where these posts exist, engagement in education and training leading to employment is higher than baseline levels of around 25% (Rinaldi et al, 2006, 2007).

COMMUNICATIONS STRATEGY

We are using every opportunity to communicate and share the learning from this Survey with all relevant stakeholders, in order to achieve comprehensive coverage. Initial results from the Survey from 7 EIP teams were presented at the London Network meeting, NIACE, Barnet College, on 3 July 2008. A focus was on the workable strategies being identified, and the experience of Lambeth EIP team and joint working with Lambeth College in active partnership development. This meeting was well attended, by further education providers, community mental health and EIP teams, PCT mental health Commissioners.

The London survey has been presented at the following forums; the London Division Executive Committee, RCPsych, 9.9.2008, the London Early Intervention in Psychosis Research Network, 11.9.2008, RCPsych CAMHS Annual Conference, 18.9.2008, and the Young Psychiatrists' Forum, World Psychiatric Association, Prague, 24.9.2008. A presentation is being scheduled with the London Forum, Medical Directors Group.

Links have also been made to the NIMHE National EI Programme National Leads Group (Jo Smith/David Shiers); national steering group, "Refresh Mental Health strategy", LSC/NIACE; Forensic Psychiatry Section, Royal College of Psychiatry; Mental Health Network, NHS Confederation, Sainsbury Centre for Mental Health, RETHINK.

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Table 1. London Audit, Early Intervention in Psychosis Teams, Active Caseload 21/06/08

| Team No. | Early Intervention in Psychosis Team | Total Number on active caseload | No. of BME Clients on caseload | % caseload BME Clients | No. on caseload involved in Training/Education | % caseload, involved in Training/Education | No. of BME clients in Training/Education | % in Training/Education who are BME clients |
|----------|--------------------------------------|---------------------------------|--------------------------------|------------------------|--|--|--|---|
| 1 | Barking & Dagenham | 39 | 27 | 69.2 | 8 | 20.5 | 6 | 75.0 |
| 2 | Barnet | 53 | 22 | 41.5 | 10 | 18.9 | 6 | 60.0 |
| 3 | Bexley | 38 | 14 | 36.8 | 15 | 39.4 | 6 | 40.0 |
| 4 | Brent | 42 | 33 | 78.6 | 13 | 30.1 | 13 | 100.0 |
| 5 | Bromley | 41 | 10 | 24.4 | 14 | 34.1 | 3 | 21.4 |
| 6 | Camden & Islington | 115 | 65 | 56.5 | 32 | 27.8 | 17 | 53.1 |
| 7 | City & Hackney | 136 | 100 | 73.5 | 37 | 27.2 | 26 | 70.3 |
| 8 | Croydon | 144 | 107 | 74.3 | 36 | 25.0 | 25 | 69.4 |
| 9 | Ealing | 74 | 55 | 74.3 | 13 | 17.6 | 10 | 76.9 |
| 10 | Hammersmith & Fulham | 60 | 50 | 83.3 | 11 | 18.3 | 8 | 72.7 |
| 11 | Havering | 59 | 12 | 20.3 | 12 | 20.3 | 1 | 8.3 |
| 12 | Hounslow | 87 | 57 | 65.5 | 14 | 19.1 | 12 | 85.7 |

NK= Not known

22.5% White British clients are in Training/Education, 24.5% BME clients are in Training/Education (Excluding Tower Hamlets team)

Table 1 cont. London Audit, Early Intervention in Psychosis Teams, Active Caseload 21/06/08

| Team No. | Early Intervention in Psychosis Team | Total Number on active caseload | No. of BME Clients on caseload | % caseload BME Clients | No. on caseload involved in Training/ Education | % caseload, involved in Training/Education | No. of BME clients in Training/Education | % in Training/ Education who are BME clients |
|---------------------------|---|--|---------------------------------------|-------------------------------|--|---|---|---|
| 13 | Kensington, Chelsea & Westminster | 123 | 108 | 88.0 | 61 | 49.6 | 52 | 85.0 |
| 14 | Kingston | 47 | 15 | 31.9 | 12 | 25.5 | 5 | 41.6 |
| 15 | Lambeth | 134 | 107 | 79.9 | 16 | 18.7 | 14 | 92.0 |
| 16 | Lewisham | 174 | 126 | 72.4 | 53 | 30.5 | 37 | 69.8 |
| 17 | Newham | 155 | 115 | 74.2 | 39 | 25.2 | 27 | 69.2 |
| 18 | Richmond | 59 | 10 | 16.9 | 9 | 15.3 | 1 | 11.1 |
| 19 | Redbridge | 83 | 59 | 71.1 | 17 | 20.5 | 11 | 64.7 |
| 20 | Southwark | 97 | 68 | 70.1 | 13 | 13.4 | 7 | 53.8 |
| 21 | Sutton & Merton | 132 | 58 | 43.9 | 11 | 8.3 | 9 | 6.8 |
| 22 | Tower Hamlets | 128 | 110 | 85.9 | 48 | 37.5 | NK | NK |
| 23 | Waltham Forest | 57 | 44 | 77.2 | 13 | 22.8 | 11 | 84.6 |
| 24 | Wandsworth | 100 | 71 | 71.0 | 29 | 29.0 | 20 | 68.9 |
| Collated Team Data | | 2177 | 1443 | 66.3 | 536 | 24.6 | 327 (Exc. Tower Hamlets) | 67.0 (Exc. Tower Hamlets) |

Table 2. Education and Work, London EIP Team Audit

| Early Intervention Team | Total No. Clients | Total No. of BME Clients (%) | Education | | | | | | | | Work | | | | | |
|-------------------------|-------------------|------------------------------|-----------|-----|---------|-----|------------|-----|-------------------------------|------------|-----------|-----|-------|-----|--------------------------|------------|
| | | | School | | College | | University | | All Education (% BME Clients) | | Volunteer | | Paid | | All Work (% BME Clients) | |
| | | | All | BME | All | BME | All | BME | All | BME | All | BME | All | BME | All | BME |
| Barking & Dagenham | 39 | 27 (69.2) | 3 | 1 | 5 | 4 | 3 | 3 | 11 | 8 | 2 | 2 | 4 | 4 | 5* | 5* |
| Havering | 59 | 12 (20.3) | 0 | 0 | 10 | 2 | 2 | 0 | 12 | 2 | 4 | 0 | 13 | 4 | 17 | 4 |
| Hounslow | 87 | 57 (65.5) | 0 | 0 | 9 | 8 | 5 | 4 | 14 | 12 | 3 | 3 | 18 | 11 | 21 | 14 |
| Lambeth | 134 | 107(79.9) | NK | 0 | NK | 13 | NK | 0 | NK | 13 | NK | 2 | NK | 6 | NK | 8 |
| Lewisham | 174 | 126 (72.4) | 3 | 2 | 39 | 28 | 11 | 7 | 53 | 37 | 12 | 8 | 46 | 34 | 58 | 42 |
| Redbridge | 83 | 59 (71.1) | 5 | 5 | 12 | 8 | 2 | 1 | 19 | 14 | 1 | 1 | 20 | 16 | 21 | 17 |
| Southwark | 104 | 72 (69.2) | 1 | 1 | 24 | 24 | 6 | 5 | 31 | 30 | 2 | 2 | 9 | 9 | 11 | 11 |
| Waltham Forest | 57 | 44 (77.2) | 1 | 1 | 10 | 8 | 2 | 2 | 13 | 11 | 1 | 1 | 10 | 10 | 11 | 11 |
| Collated Teams | 650 | 447 (68.8) | 13** | 10 | 109** | 95 | 31** | 22 | 153** | 127 (28.4) | 25** | 19 | 120** | 88 | 144** | 112 (25.1) |

*1 client in both paid and volunteer employment **= Excluding Lambeth NK=Not Known

Table 3. Education and Work by Ethnic Category, London EIP Team Audit

| Ethnicity | Total Caseload Number | % of Total BME Caseload | Mean Age (Update) | Gender | | Education | | | | Work | | |
|--------------------------------|-----------------------|-------------------------|-------------------|---------------|--------------|-----------|---------|------------|---------------|-----------|------|----------|
| | | | | Male | Female | School | College | University | All Education | Volunteer | Paid | All Work |
| Black African | 51 | 28.3 | 24.4 | 33 | 24 | 3 | 25 | 3 | 31 | 1 | 17 | 21 |
| Black Caribbean | 56 | 31.1 | 23.7 | 32 | 18 | 0 | 26 | 5 | 31 | 7 | 22 | 29 |
| Mixed Black African/ Caribbean | 2 | 1.1 | 25.5 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 2 | 2 |
| Mixed White & Black | 9 | 5.0 | 21.8 | 7 | 2 | 1 | 5 | 0 | 6 | 0 | 3 | 3 |
| Indian | 15 | 8.3 | 28.0 | 9 | 6 | 2 | 4 | 2 | 8 | 0 | 7 | 7 |
| Pakistani | 12 | 6.7 | 28.1 | 8 | 4 | 0 | 3 | 1 | 4 | 1 | 8 | 9 |
| Bangladeshi | 4 | 2.2 | 22.0 | 2 | 2 | 1 | 1 | 0 | 2 | 0 | 2 | 2 |
| Other Asian | 7 | 3.9 | 24.1 | 6 | 1 | 1 | 1 | 0 | 2 | 0 | 6 | 6 |
| Others | 24 | 13.3 | 22.9 | 12 | 12 | 0 | 4 | 4 | 8 | 3 | 13 | 16 |
| Total | 180 | 100 | 24.3 | 109 (60.6) | 71 (39.4) | 8 | 69 | 15 | 92 | 16 | 78 | 95 |

% Black African + Black Caribbean + Mixed Black African/ Caribbean + Mixed Black/White = 65.5

% Asian = 21.1

Note: Black British included as Black Caribbean

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