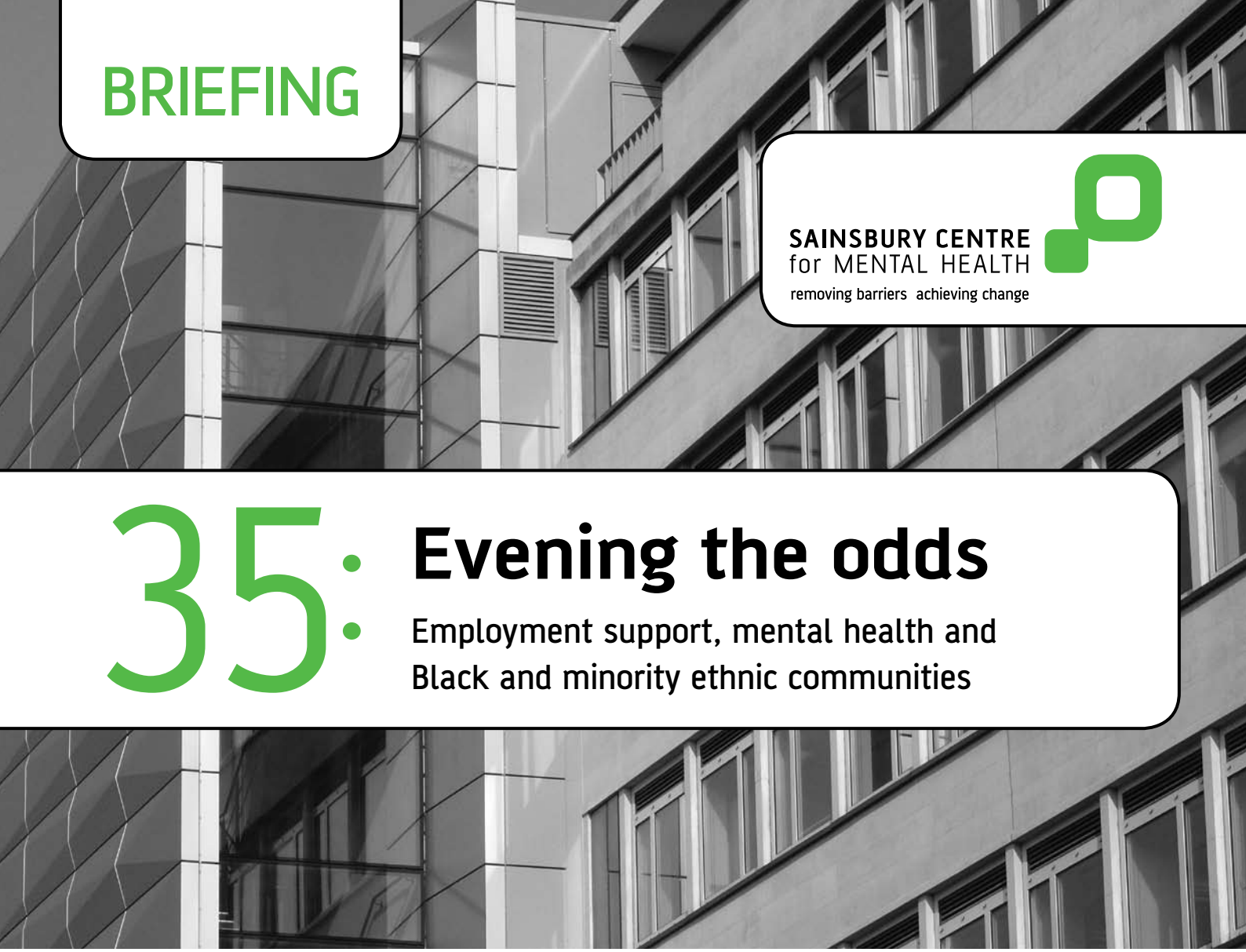


BRIEFING

SAINSBURY CENTRE
for MENTAL HEALTH
removing barriers achieving change

35: Evening the odds

Employment support, mental health and Black and minority ethnic communities

Summary

People from Black and minority ethnic communities are less likely to use employment support services and less likely to succeed in gaining employment than their white British peers.

Specialist mental health employment support staff need to adopt an evidence- based approach with the capacity to address issues of racism and stigma.

Where existing services for getting people into employment are not working so well for Black and minority ethnic clients, a targeted approach should be taken.

The five key actions in a targeted approach to meet the needs of all users of mental health services are:

1. **Improve mental health care for Black and minority ethnic communities, e.g. through:**

- A greater focus on recovery and support for an active lifestyle;
- Increasing the proportion of service users from all local communities in the mental health care workforce;
- A diverse workforce with evidence-based staff training and supervision.

2. **Broaden the range of resources for recovery, e.g. through:**

- Working in partnership with community groups to deliver culturally specific options, including
  - Arts, sports and educational activities;
  - Appropriate training and voluntary work opportunities.

3. **Enhance the skills of employment workers by:**

- Adopting the individual placement and support (IPS) approach;
- Increasing skills and confidence in addressing racism issues;
- Helping service users who want to start their own business.

4. **Inform and monitor change by:**

- Ensuring service users participate in the development of services;
- Monitoring the impact of employment support.

5. **Promote wellbeing and community cohesion:**

- Raise the profile of mental health promotion locally among public services;
- Develop targeted mental health promotion programmes which increase educational and employment opportunities for all young people.

Introduction

There is substantial research into employment issues for people with mental health problems (Sainsbury Centre, 2007), but little of this is focused on the needs of Black and minority ethnic communities. Yet there is evidence that people in these communities benefit less than the wider population from both mainstream and specialist mental health employment services. This paper explores the reasons for this and offers some practical, evidence-based ideas for improvement.

A national study of six major employment services for people with mental health problems and disabilities found that people from Black and minority ethnic groups were significantly less likely to move into work. The authors commented:

"Although this might at first sight be related to the finding that these participants were also more likely to be experiencing more severe mental health problems, this seems unlikely since severity of problems was not itself a barrier to work." (SESAMI, 2006)

Similarly, it is has been reported that Black and minority ethnic groups have benefited less than the wider population within some government programmes in the labour market (Strategy Unit, 2003). Assumptions about the impact of educational attainment are often incorrect:

"Educational underachievement is a significant factor... in general, however, the employment disadvantage remains once differences in educational attainment are taken into account." (Strategy Unit, 2003)

There is evidence that generic approaches to employment support often fail to achieve equal outcomes because of the complex and varied nature of the issues (Strategy Unit, 2003). But treating people differently simply because of their ethnicity is not the solution either. Some individuals will benefit from culturally specific services while others will wish to use mainstream services on an equal basis with others.

The aim must be to provide an individually tailored, person-centred approach for *all* people using the service. Where some groups are not faring as well as others, we suggest that targeted action is introduced in partnership with other local services that can help.

This briefing suggests some targeted actions that might help to make change happen. We hope it will be helpful to commissioners, service providers and community organisations.

The briefing is based on the experience of the employment programme at the Sainsbury Centre together with partners we have worked with over many years, but we are the first to admit that there is more to learn.

Box 1: Who are we talking about?

We use the phrase 'Black and minority ethnic communities' to include all people who are not White British. We therefore include those who are Irish, East European and Other White groups, unlike the Labour Force Survey (ONS, 2007) which puts all white people into one category.

Diversity between ethnic groups is arguably greater than any similarities they may have, and groups fare differently in both the job market and mental health system.

Of course, employment opportunities are influenced by many factors, including age, gender, education, social class and geography. Ethnicity does not always have an impact on success in the labour market, but research suggests that for many people, it does.

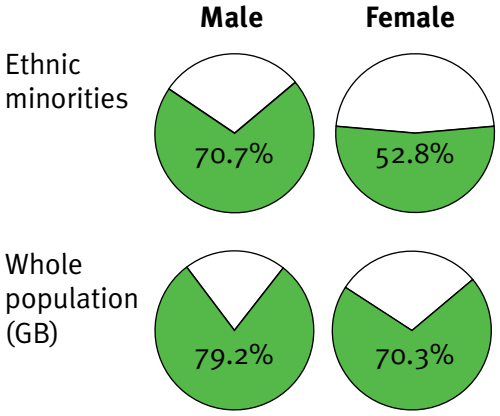
The job market

As a whole, people from Black and minority ethnic groups are less likely to find and sustain employment than their white counterparts (Strategy Unit, 2003). There is a persistent, albeit narrowing, gap in unemployment rates, which now stand at 13.2% (ONS, 2007). Hence while three-quarters of the white labour force are in employment only three-fifths of all Black and minority ethnic people are in paid work. This figure hides wide variations across ethnic groups (see Table 1).

Since 2005, the proportion of Black African people in work has increased, but their rate of employment is still about 10% lower than average. The proportion of Black Caribbean people and those described as 'Other Black' (largely second or third generation African and Caribbean people) in work is actually falling. Young men in these categories are more disadvantaged than women from the same communities, who achieve better at school, in jobs and in business (Strategy Unit, 2002).

The employment rate for Bangladeshi people is about 32% lower than for the white population, with men more likely to be employed than women. There is a similar pattern in the Pakistani population but Indians have a higher rate of employment, currently about 6% lower than white people, and a greater proportion of Indian women are in employment.

Figure 1: Proportion of working age adults in paid employment in Great Britain



Source: Labour Force Survey (ONS, 2007)

The number of people from Black and minority ethnic groups in self-employment has increased since 2005, among women more than men. African and Caribbean people are two to three times more likely than white people to be social entrepreneurs (Harding, 2006). Mental health service users from Black and minority ethnic communities have expressed a strong interest in enterprise (SEU, 2004).

Table 1: Labour force status by ethnic group, July – September 2007

Ethnicity	Employment rate		
	Male	Female	All
White	80.2%	72.5%	76.5%
Mixed	66.5%	61.4%	63.9%
Indian	77.2%	62.4%	70.2%
Pakistani	65.3%	28.0%	46.8%
Bangladeshi	58.7%	29.5%	44.1%
Other Asian	77.7%	56.3%	67.1%
Black Caribbean	69.2%	65.3%	67.0%
Black African	72.8%	54.7%	63.6%
Other Black	70.5%	*	64.7%
Chinese	65.0%	57.0%	60.8%
Other	70.0%	53.0%	61.4%
Ethnic Minorities	**70.7%**	**52.8%**	**61.6%**
Whole Population (GB)	**79.2%**	**70.3%**	**74.9%**

Source: Labour Force Survey (ONS, 2007)
(*sample size too small for reliable estimates)

Experiences of the mental health system

Disproportionately high numbers of some Black and minority ethnic groups are treated in the mental health system. Here their experiences are often harsh (Walls & Sashidharan, 2003), with high levels of detention, seclusion, restraint and assault. The Healthcare Commission's *Count*

Me In census found people in the 'Other Black' category have admission rates which are 14 times higher than average (19 times higher for men, seven times higher for women). Lengths of stay in hospital are also significantly higher than average for many minority groups (Healthcare Commission, 2007).

The causes are complex and subject to debate, with no single factor able to explain the stark differences that have been documented (Sainsbury Centre, 2006). Many speak of institutional racism within mental health services (Blofeld *et al*., 2004; McKenzie & Bhui, 2007) and other institutions central to our lives. Other suggested causes include the pressures of life in a discriminatory society, exclusion from school or academic under-achievement, the consequent lack of employment opportunities mentioned here and the absence of hope. Issues arising from a mixed heritage may be a factor for some people.

Despite all this, our experience suggests that many people with mental health problems from Black and minority ethnic backgrounds want to work and study, but they are not given appropriate help to do so (Secker *et al*., 2001; Seebohm *et al*., 2003).

A study of African and Caribbean men and women (16 men, two women) detained under the Mental Health Act found that over half (61%) had previously been employed and most had studied beyond school (78%) including seven (39%) at university. None were employed at the time of the study, and the author notes their unfulfilled potential (Sandhu, 2007).

For people with mental health problems, diagnosis and hospitalisation are poor predictors of employability. The overriding factor is having a strong desire to work (Grove & Membrey, 2005). This suggests that many service users from Black and minority ethnic communities could get paid employment.

The barriers to work

The average employment rate for the UK working age population is 74%. But it is only 21% for people with long-term mental illness. There are barriers to work for *all* people who have used mental health services including the benefits system, stigma of mental ill-health, and lack of encouragement from mental health staff (Box 2).

Box 2: Barriers to employment (from Sainsbury Centre, 2007)

- **Financial disincentives**: Many fear that they will lose their entitlement to benefits before they can cope with an ordinary job.
- **Stigma and discrimination**: Fewer than four in ten employers say they would recruit someone with a mental health problem.
- **Low expectations and lack of resources**: Low expectations by health care staff can hinder a person's return to work. Talking therapies can play a role in helping people to remain in work but access to these is often poor.

In addition to the obstacles that apply to all people with mental health problems, extra barriers are faced by many people from Black and minority ethnic backgrounds. They include:

Low expectations

The low expectations mental health staff have of service users appear to be more entrenched for Black and minority ethnic people. This mirrors the attitudes that may have been displayed by teachers and employment agency staff. Such low expectations can become internalised, creating a self-defeating spiral of hopelessness.

Racism

Racism is rooted in our history. It is pervasive and cannot be ignored. Direct racism is unlikely in a good service, but practitioners may behave in a way which 'unwittingly' creates a disadvantage for some groups, as found in our schools (DfES, 2006) and among employers (Strategy Unit, 2003).

Racist abuse and discrimination can themselves cause mental ill health. But individuals vary in their experiences and it will be more of a concern for some than for others (Karlson, 2007). Racism in the workplace, direct or indirect, makes it hard to get and sustain employment (Seebohm *et al*., 2003).

Stigma of mental illness

There are parallels between 'institutional racism', as described in the Macpherson report into the death of Stephen Lawrence (1999) and the discrimination which 'often appears to be unintentional' that is experienced by people with mental health problems in every aspect of their personal, social and working lives (Thornicroft, 2006). This cumulative discrimination may help to explain why African and Caribbean men in the mental health system are sometimes perceived as 'mad, bad and dangerous' (Sainsbury Centre, 2002). It may also explain the increasing discrimination against Muslim neighbours with mental health problems in comparison with their white counterparts (Rethink, 2007).

At the same time, mental health problems are deeply stigmatised within many communities. Families are often supportive, but mental ill health can bring shame and fear, reducing the likelihood that people in need will seek help or find it easy to regain their self-esteem.

Education and training

Academic under-achievement leaves many men without the qualifications they need to earn a good income. They may be supported into unskilled jobs as a useful step forward, but career development is needed to ensure job retention. Full-time college can for many seem reminiscent of unhappy experiences at school.

A risk averse mental health service

Many people from Black and minority ethnic backgrounds complain that mental health services focus primarily on medication, maintenance and control (Mental Health Act Commission, 2008; Sandhu, 2007). Appropriate opportunities for recovery are limited.

Relatively few Black and minority ethnic service users choose to use mental health employment projects, which can seem inappropriate to their needs perhaps due to their setting, approach or mental health label (Pozner *et al.*, 1996; Seebohm, 2001).

Asylum seekers, refugees and migrant workers

Asylum seekers have no right to get a job in the UK, but voluntary work and study help to prepare them for employment and alleviate the stress of their situation.

Refugees (people who have been given the right to remain in the UK) have the right to work. Many are highly skilled, but opportunities may be limited by poor language skills and unrecognised qualifications.

Most migrant workers from Eastern Europe find work easily. But some do not. Without language skills they can find it hard to get help, decent housing or social networks (JRF, 2007). Increasing numbers are using mental health services (Healthcare Commission, 2007).

Employers can be reluctant to employ people without British passports, and some, including the civil service, require UK nationality.

The levers for change

The Race Relations Amendment Act 2000 imposes a duty on public authorities to actively promote race equality. Details are available from the Equality and Human Rights Commission (www.equalityhumanrights.com).

The NHS and social services are also held accountable by the planning framework, *National Standards, Local Action,* (DH, 2004). This requires both organisations to challenge discrimination, promote equality and respect human rights. They must enable all members of the population to access services equally.

The Government's action plan, *Delivering Race Equality* (Department of Health, 2005), requires mental health services to develop a recovery focus for people from Black and minority ethnic communities. They should offer equal access, experience and outcome. The plan provides a useful framework for local implementation of the legal and policy obligations for race equality.

Empowerment and choice, combined with social and economic inclusion are mainstream policy concerns throughout the mental health and public health agenda, at strategic, management and care-planning levels (e.g. Department of Health, 2006; Department of Health, 2007a).

The Local Government and Public Involvement in Health Act 2007, meanwhile, aims to ensure that all community groups have their say in shaping health services. Local people should be involved in all aspects of the commissioning cycle.

Implemented properly, this should give Black and minority ethnic communities more of a say in the way health services meet their needs.

As well as policy drivers, there is also a business case for change. If services deliver what people want, relationships between practitioners and service users should improve, promoting both health and safety. Enabling people to get work improves their mental health, prevents suicide and reduces reliance on health services (SEU, 2004).

Improving the employment prospects of people from Black and minority ethnic communities should be fundamental to any attempt to achieve 'world class commissioning' in the NHS (Department of Health, 2007b; Department of Health, 2007c). 'World class commissioning' is seen to promote wellbeing, reduce health inequalities and increase inclusion. It requires local leadership and collaborative partnerships. It involves engaging with local communities, working closely with clinicians, managing knowledge, prioritising improved outcomes, influencing and shaping the market, and promoting innovation and improvement.

What can be done?

Mental health services need to improve their capacity to respond to an ever-changing population. They need to focus on recovery, with access to a range of appropriate resources, including employment support staff who have the skills to address the dual barriers of racism and stigma in the job market. There is a vital role for the voluntary and community sector in this process of change.

Strong leadership, a strategic approach based on what is known to work and careful monitoring will help to bring about change and measure progress.

1. Improve mental health care

Most service providers are already introducing measures to achieve change. To support this we suggest:

- Increasing staff capacity to develop positive and trusting relationships with people from Black and minority ethnic communities, for instance by:
  - Engaging with the perspectives of service users from Black and minority ethnic groups, e.g. through drama and community events;
  - Training and supervision to develop new ways of working, e.g. evidence-based race equality and cultural competence training (Bennett *et al.*, 2007) and values based practice (Woodbridge & Fulford, 2004).
- Increasing the recovery focus, e.g. by:
  - Working with service users to learn about their self-defined goals;
  - Giving staff the flexibility, skills and resources to help service users to achieve those goals;
  - Ensuring the type and level of medication prescribed supports rather than hinders activities that help with recovery (Shepherd *et al.*, 2008).
- Reviewing processes to increase the number of people (including service users) from local communities at all levels of the workforce.

2. Develop resources for recovery

Mental health services should aim to develop a range of appropriate recovery focused options which enable all people to move towards employment.

Some existing initiatives target specific groups and report significant benefits, while others provide a setting and delivery style which is inclusive for all service users. The activities involved, such as arts, peer support, or personal development, may be similar in both types of initiative. Successful examples of culturally specific initiatives include creative expression for Black men (Friedli *et al.*, 2004) and peer support for Muslim women (Thomas *et al.*, 2006). Successfully inclusive projects were found in a study of art and mental health (Secker *et al.*, 2007). We suggest there is a need for both culturally specific and inclusive projects where there is a mixed population.

An individual's sense of identity and pride is an important factor in their recovery and therefore in their ability to sustain employment. Family, peers and community agencies can help to instil self-esteem and reduce the impact of racism. The confidence and self-belief which follows can be a crucial factor in getting a job.

Recovery focused initiatives might include culturally specific and inclusive opportunities for:

- Personal and health development opportunities, e.g. arts, sports, music, literacy and numeracy learning;
- Service user involvement activities (paid) which lead to demonstrable change in service provision;
- Access to education, training, voluntary and sessional paid work;
- Peer group activities, including self-help and mutual aid;
- Role models, e.g. through peer groups, user employment in the NHS, community activities, mentoring, and staff with the same background.

Community-led, non-stigmatising services can deliver these initiatives in partnership with statutory services. Commissioners can help to build the capacity of these organisations so they can make sustainable partnerships which provide people with access to study and work. Community development workers can help to facilitate this process (Seebohm *et al.*, 2005).

Commissioners and providers can increase access to individually tailored funding, for example through individual budgets and direct payments, to increase the flexibility of the services they offer.

3. Enhance the skills of employment workers

A strategic approach to vocational services (as recommended in the commissioning guidance, CSIP, 2006), together with the following actions, may promote equality of achievement.

- Adopt the 'individual placement and support' (IPS) model which can achieve good outcomes regardless of gender, ethnicity or diagnosis (see Sainsbury Centre, 2007 or SEU, 2004). Commissioning guidance calls for IPS in every mental health service in England (CSIP, 2006).
- IPS requires joint working between the service user, mental health practitioner and employment worker prior to *and after* gaining employment. Where the service user does not have or does not wish to involve a mental health practitioner, try to arrange emotional support from an acceptable source in the voluntary sector.
- Ensure employment workers have a good awareness of racism and the confidence to address employers' anxieties. Aim to identify workplaces which will be respectful, and develop contacts in diverse business networks.
- Offer a flexible, informal approach, meeting up in community settings. Where job skills are lacking, aim for a combination of paid work and training with a clear focus on self-defined goals.
- Use peer support, role models and community resources to inspire hope and confidence.
- Provide access to enterprise support that is sensitive to mental health issues for those who want it. Self-employment can increase self-determination and avoid discrimination in the job market, but is not an easy option (Hallam & Seebohm, 2007).

4. Inform and monitor change

- Ensure service users, carers and others from Black and minority ethnic communities inform the development of mental health and employment services.
- Monitor the ethnicity of people accessing relevant services and what that achieves in terms of education, training and work. Information about different teams can reveal differences across the service and should support skills-sharing.
- Monitor model fidelity of the employment support service (i.e. how closely it follows the principles of IPS). Key performance indicators to help with this process are currently in development at the Sainsbury Centre: for updates go to www.scmh.org.uk.

5. Promote wellbeing and community cohesion

- Raise the profile of mental health promotion within strategic partnerships: for example in local area agreements.
- Increase awareness of the connections between mental health, education, employment, community cohesion and sustainable communities for Black and minority ethnic groups.
- Develop initiatives for young people which target or positively include those from Black and minority ethnic groups, to promote educational and employment opportunities and thereby reduce the risk of mental ill health.
- Fund community agencies and community development workers to promote wellbeing and improve access to emotional and employment support for people from Black and minority ethnic communities.

AKABA

AKABA was set up in Hackney in 2003 to enable young Black men with mental health problems to get access to education, training and work. It is based within Kush Supported Housing and Care Services, which provides a range of community based interventions for people of Black, African and Caribbean background. Kush is funded by City and Hackney (Teaching) Primary Care NHS Trust, Hackney Social Services and The Big Lottery.

After an initial three year grant from the London Development Agency, AKABA is now funded by the primary care trust to employ one full-time employment support worker. The Big Lottery funds a full-time employment development worker and part of the salary of a senior manager, with a view to developing the project into a social enterprise.

AKABA's client group of men aged 18 to 45 years includes those who use mental health services and others felt to be at risk. Services will be extended to women in the future.

Staff liaise with community mental health teams and hold surgeries at Homerton Hospital. They work closely with Jobcentre Plus, with other employment services and with many statutory and voluntary sector agencies. AKABA's service users meet weekly to share experiences and contribute to service planning.

During 2006-2007, despite only having one part-time worker in post (between past and present funding arrangements), AKABA got 13 people into paid employment and 19 into training and / or voluntary work. An evaluation found that AKABA was highly valued by service users and local agencies for its unique contribution in Hackney (Seebohm & Philip, 2006).

"They are encouraging and promoting a positive image about young Black men... That is the only way you are going to motivate and prepare a lot of young Black men to do positive things."

(Service user)

"It's the expertise with education and training and the fact that it's targeted to Black males with emotional problems – its got three very strong, very specific things going for it."

(Probation officer)

Sharing Voices

Sharing Voices (Bradford) is a community development project working with people from all Black and minority ethnic communities. Funded by Bradford City (Teaching) Primary Care Trust, it liaises with statutory services to improve mental health services, to stimulate and support development within the voluntary and community sectors, and to encourage debate about diverse perspectives of mental health.

People who have experienced the full spectrum of mental health issues value the project for its spiritual support, encouragement and commitment to self-help and mutual aid (Seebohm *et al*., 2005).

In 2003, the project received a one year grant for an employment worker. During the year, 15 people were supported into paid work, nine into education, and six into other daytime activities. Partnerships included Jobcentre Plus, Bradford College, Remploy and the Bangladeshi Youth Organisation.

Funding for the post was not continued, and there is no employment service on the individual placement and support model in the area, but community development workers continue to liaise with relevant agencies and help individuals to get into work and college. A key feature of the project is the way people gain confidence and hope with a new perspective on life after getting involved in peer support and community development activities.

"When I first started with Sharing Voices, I didn't want to talk to no one... I was lost. The people, the staff, they believed in me, they said 'You can do it. I know you can do it'. But I didn't have that belief from anyone [else]... And [now] I'm at uni and I'm getting good results... I can't believe it."

(Employment participant)

"It made a big difference because I've loads of confidence now, I could talk to anyone. I didn't work before... I was sat at home... but I've started trying to do everything now. I've applied for a few jobs."

(Peer group participant)

Acknowledgements

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Briefing 35: Evening the odds

Employment support, mental health and Black and minority ethnic communities

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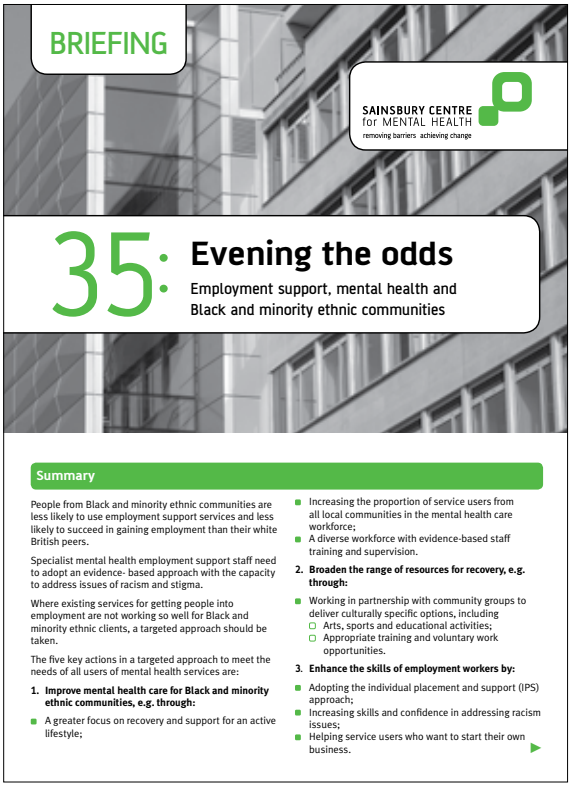

Summary

People from Black and minority ethnic communities are less likely to use employment support services and less likely to succeed in gaining employment than their white British peers.

Specialist mental health employment support staff need to adopt an evidence- based approach with the capacity to address issues of racism and stigma.

Where existing services for getting people into employment are not working so well for Black and minority ethnic clients, a targeted approach should be taken.

The five key actions in a targeted approach to meet the needs of all users of mental health services are:

1. **Improve mental health care for Black and minority ethnic communities, e.g. through:**
   - A greater focus on recovery and support for an active lifestyle;
   - Increasing the proportion of service users from all local communities in the mental health care workforce;
   - A diverse workforce with evidence-based staff training and supervision.
2. **Broaden the range of resources for recovery, e.g. through:**
   - Working in partnership with community groups to deliver culturally specific options, including
     - Arts, sports and educational activities;
     - Appropriate training and voluntary work opportunities.
3. **Enhance the skills of employment workers by:**
   - Adopting the individual placement and support (IPS) approach;
   - Increasing skills and confidence in addressing racism issues;
   - Helping service users who want to start their own business.

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