Service Evaluation: Care Coordinator perspectives on support around employment and vocational activity

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Lambeth Black Thrive

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Executive Summary

Objectives & Method

This service evaluation involved conducting semi-structured interviews with six Care Coordinators from across the South London and Maudsley (SLaM) community teams in Lambeth to investigate:

- the extent to which Care Coordinators feel they are able to promote and support employment and other vocational activity as objectives for service users;
- how well the culture, policies, processes and resources of SLaM support them in this;
- how the race and ethnicity of service users might affect access to and experience of support around employment and other vocational activity

We focused on the views and experiences of Care Coordinators rather than assessing the quality and capacity of SLaM's own employment support services.

Findings & Discussion

The key themes that emerged from an analysis of these interviews included:

1) Prioritisation of employment/vocational activity at service and organisational level

From our interviews, the overall picture was that employment and other vocational activity are seen as important objectives in theory, but in practice they are not given much resource, and are not strongly promoted through mechanisms such as KPIs and the CPA process. This contributes towards these objectives becoming a lower priority on a day-to-day basis.

> *We are very focused, obviously, on someone's mental health and physical health, and there is a real push at the moment to measure those things in KPIs... Do I feel that other things that are possibly just as important to our service users - like getting a job - (are) valued or measured as much? No, I do not, and I think that it could be*

2) Care Coordinators' desire and capacity to focus on employment

Employment and other vocational activity is seen by most Care Coordinators as important and valuable to service users. The size of caseloads was a key barrier to Care Coordinators focusing more time on these objectives, as they reported having insufficient time to do so and being pulled towards dealing with crises rather than longer-term goals.

> *It's getting increasingly more difficult to have the space and time to be having those conversations with people and supporting them with some of the things we might identify, because the caseloads are just getting higher and it only takes one crisis to kind of take up your week really, and then you are sort of forever playing catch up*

3) Nature of employment/vocational support available

There was a mixed response in terms of Care Coordinators' awareness of what support was available around employment and other vocational activity, both within and outside of SLaM, and their perceptions of the quality of this support. Those working in teams with specialist employment/vocational staff valued this support but felt it was under-resourced.

> *We don't have enough of that in the team. Even having one IPS worker and one vocational worker... it's probably not enough for the number of people that we have got*

> *I feel like it is all quite like bitty across community organisations and different staff that we have here at SLaM, so being able to pull that all together (would help)*

4) Barriers to accessing employment/vocational activity

A range of barriers were noted, including those stemming from service user circumstances, service constraints, employer attitudes and the benefits system. 'Work readiness' was seen as being shaped not only by the impact of someone's mental health problems, but also by how 'unwell' they perceived themselves to be, and how this had been shaped by their experience of services.

> *We talk about employment a lot with people. Some of them will say, "Oh I am not ready". There's a lot of reluctance... It could be their anxiety, it could be because they have been out of work for a long time, they don't know how to socialise with people*

5) How race and ethnicity impact on service user experiences

Overall, there was a recognition that race and ethnicity might play a role around aspects of assessment, medication, and clinical treatment within mental health services; this was linked to cultural misunderstandings and (mis)interpretations of behaviour. However, there seemed to be less of a perception of differential treatment around employment support.

> *I think in regards to assessment there's a cultural difference. There is definitely a cultural difference, because I have seen where a psychiatrist is assessing a client and they don't understand what the client is saying, but yet still you're assessing them, and you're making judgements based on what they're saying but you don't understand what they're saying*

Conclusions & Recommendations

Given the small sample size, we cannot draw definitive conclusions or recommendations. However, the research clearly points to issues that need addressing. These issues should be investigated further in collaboration with staff and service users, who should also be involved in developing solutions. However, based on our findings we have suggested some broad recommendations to help guide and inform this process:

1) Employment and other vocational activity should be given higher status and priority at an organisational and strategic level

- Review the extent to which these objectives are meaningfully prioritised in the Trust's strategy and how this is supported through policies, processes and measurement
- Clear and regular communication across the Trust that emphasises the importance of these objectives, highlights available services and support, and demonstrates the potential impact through case studies of service user outcomes

2) Team objectives and processes should incentivise staff to ensure service users are supported and encouraged around employment and other vocational activity

- Engagement with support around employment and other vocational activity across a team's caseload should be recorded and reported as a KPI
- Tools such as Dialogue may help to better incorporate and reflect these kind of objectives and activities in formal KPI reporting
- Up-to-date employment and benefit statuses should be recorded on service users' notes and changes in status should be reported on a regular basis
- The CPA process, or any processes that replace CPAs in the future, should more explicitly focus on employment and other vocational activity

3) Greater attention should be given to the impact of high caseloads on the ability of staff to focus on longer-term objectives such as employment

- Investigate and monitor how the size of caseloads impacts on the ability of staff to focus on longer-term social objectives such as employment
- Use this evidence to make the case to commissioners, NHS England and central government that high caseloads are restricting capacity to deliver these objectives

4) In-house support and opportunities with SLaM around employment and other vocational activities should be better resourced and utilised

- Review the take-up and outcomes of existing in-house support services to investigate how well they are being utilised and to develop a business case for greater investment in these services and resources
- Efforts should be made to ensure all staff in community teams are aware of support and resources available within SLaM and rates of referral should be monitored
- Care Coordinators and other staff should be offered support and advice on how to directly support service users towards employment and other vocational activity
- Consider how SLaM can offer more direct opportunities to service users through contracting of services, such as cleaning

5) There should be more collaboration and integration between SLaM and community organisations offering support around employment and other vocational activities

- Ensure staff have easy access to a comprehensive and up-to-date directory of available support from community services and are encouraged to utilise this
- Collaborate with the 'No Wrong Door' project to better support service users to access appropriate support from community organisations quickly and easily
- Consider the challenges faced by service users with previous experience or qualifications, whose needs and aspirations might not be adequately catered for by services more focused on basic skills and entry-level jobs

6) Access to support around employment and other vocational activity should be considered as part of efforts to address racial and ethnic inequalities across SLaM

- Explore with staff whether there is a risk that service users from minority ethnic groups are treated with different perceptions and expectations around objectives such as employment, and what could be done to correct for any bias

- Ensure Care Coordinators and other staff are aware of culturally appropriate community services that they can refer people onto for support with these objectives
- Consider how support around employment and other vocational activity for minority ethnic groups could be incorporated into relevant policies and strategies, such as the Patient and Carer Race Equality Framework (PCREF)

02

Introduction

> *For the past 5 years my son who is in his mid-30s, with a psychosis diagnosis, has been saying he wants to work. Despite having a professional background in the public sector that allows me to be an effective advocate for my son, it has proved extremely difficult and frustrating for me to find employment support for him in Lambeth. My family has lived in Brixton for over 60 years, so I know the borough well.*
>
> *A breakthrough came just over a year ago, when a psychologist, with whom I had shared my frustration, overheard a conversation in her team about a carpet cleaning social enterprise offering paid work. While still very much under-employed, my son has been working a day a week for the past 12 months, gaining valuable work experience and a huge boost in self- esteem. It's the one day of the week that he needs no prompting. He is up early, washed, dressed and ready to leave for work. Finding appropriate employment support to help him to move forward with his aspirations, remains challenging.*
>
> ***Parent of SLaM service user***

Employment, and other vocational activity (such as volunteering, training or education) can provide purpose, routine, dignity and independence, which in turn can help to significantly improve someone's mental health and wellbeing. As such, finding ways to improve the employment and vocational support available to service users, and encouraging people to engage with this support, should be a key priority for NHS mental health services.

This service evaluation was intended to contribute towards a better understanding of how effectively South London and Maudsley NHS Foundation Trust (SLaM) supports service users within community-based services to work towards vocational objectives such as employment, and what can be done to improve this support.

The purpose of the service evaluation, as set out in our original proposal, was to:

> *gather the views of a range of relevant members of staff regarding the current quality of, and access to, support around employment and wider vocational activity for SLaM service users. We will have a particular focus on whether the experiences of Black service users might be any different to that of the wider cohort.*

However, as we progressed with the project it became clear that a small sample of Care Coordinator perspectives was not a sufficient basis to comment on the quality of SLaM's own employment support services. As such, a more specific set of objectives emerged, which were to explore:

- the extent to which Care Coordinators feel they are able to promote and support employment and other vocational activity as objectives for service users;
- how well the culture, policies, processes and resources of SLaM support them in this;
- how the race and ethnicity of service users might affect access to and experience of support around employment and other vocational activity

This service evaluation involved a collaboration between members of staff at SLaM, King's College London (KCL) and Black Thrive Lambeth, an organisation focused on addressing the inequalities that negatively impact the mental health and wellbeing of Black people in Lambeth. The lead members of staff were:

- Tom Pollard (t.h.pollard@gmail.com) - Research Associate with Black Thrive Lambeth who coordinated the project, conducted the interviews and led the production of this report. Tom is also a Social Worker and has previously worked as a Care Coordinator in community mental health services in Camden.
- Sarah Dorrington (sarah.dorrington@kcl.ac.uk) - Psychiatrist at SLaM and Clinical Researcher at King's College London who supported the design and implementation of the service evaluation.
- Annie Irvine - Postdoctoral Research Associate at King's College London who analysed the interviews and wrote up the findings for this report.

Additional advice and support was provided by a wider project group including Catherine Crawford, Celestin Okoroji, Lela Kogbara, Yasmin Ibison and Jasmine During from Black Thrive Lambeth, and Mark Bertram (Service Manager of Lambeth Vocational Services) and Lee Roach (Head Occupational Therapist) from SLaM. This report sets out the background to the service evaluation, including the local and national context; the aims and objectives of the service evaluation; our approach and methods for data collection and analysis; the findings from our data; a discussion of these findings; and our conclusions and recommendations for policy, practice and future research.

03

Background

It is well documented that Black people experience disproportionately high rates of mental health problems, particularly the type of severe diagnoses that lead to them being under the care of secondary mental health services. Despite this high prevalence of mental health problems, Black people have poorer access to services, experiences of support, and quality of outcomes.[1] We also know that both people with mental health problems and Black people face significant disadvantages in the labour market, and that these disadvantages are amplified at their intersection.[2]

Good work, where people are well supported, is strongly associated with improved mental health, whereas unemployment is strongly associated with poor mental health.[3] Employment support within mental health services offers a key opportunity to aid someone's recovery from their mental health problems and to try and address some of the inequalities and disadvantages highlighted above. Indeed, employment support embedded within mental health services has been shown to be effective at helping people, even those with considerable 'barriers', to move into work.[4] Recent research has shown that such support may actually disproportionately benefit Black service users, with a higher proportion of this group accessing Individual Placement and Support (IPS) services across two different mental health trusts, compared with other ethnic/racial groups.[5]

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[1] Race Equality Foundation & VCSE Health and Wellbeing Alliance (2019) Racial disparities in mental health: Literature and evidence review

[2] Carnegie UK Trust, UCL Centre for Longitudinal Studies & Operation Black Vote (2020) Race Inequality in the Workforce: Exploring connections between work, ethnicity and mental health

[3] Public Health England (2019) Health Matters: Health and work; The Health Foundation (2021) Unemployment and mental health

[4] Bond, G. R., Drake, R. E., and Campbell, K. (2016). 'Effectiveness of individual placement and support supported employment for young adults'. Early Intervention in Psychiatry, 10(4), 300–307.

[5] Perkins, R., Patel, R., Willett, A., Chisholm, L., & Rinaldi, M. (2021). Individual placement andsupport: Cross-sectional study of equality of access and outcome for Black, Asian and minority ethnic communities. BJPsych Bulletin, 1-6

Evidence suggests that people experiencing mental health problems, including more severe diagnoses, often have aspirations to work.[6] We know from previous research that, historically, employment support has often not been offered or available to mental health services users within SLaM, and that this is even more pronounced for Black services users.[7] However, this research was conducted 15 years ago and, since that time, there has been considerable emphasis within the NHS, the Department of Health and the Department for Work and Pensions on improving access to employment support for people experiencing mental health problems.[8]

Given this context, it seemed appropriate and worthwhile to seek the views of Care Coordinators on how well equipped, supported and incentivised they feel to promote employment and other vocational activity with service users; and what role, if any, they feel the race and ethnicity of service users plays in these efforts and interactions.

These headline statistics about the population, employment rates and mental health service use in Lambeth, subdivided by race/ethnicity, provide some context for this report:

- Lambeth has a population of around 322,000, 238,000 of whom are of working age[9]
- In 2016, around 40% of people in the borough were White British, with another 15% from other White backgrounds; and 30% were Black (9% Black Caribbean, 12% Black African, 10% Black other)[10]
- In 2020, the working age employment rate for the borough was 77% - 81% for White residents, 69% for residents from all ethnic minorities, and 58% for Black residents[11]
- Black residents were overrepresented, compared to the baseline population, in almost all community and acute mental health services[12]

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[6] Marwaha, S. and Johnson, S. (2005) 'Views and Experiences of Employment among People with Psychosis: A Qualitative Descriptive Study', International Journal of Social Psychiatry, 51(4), 302– 316; Secker, J., Grove, B., & Seebohm, P. (2001). Challenging barriers to employment, training and education for mental health service users: the service user's perspective. Journal of Mental Health, 10, 395-404.

[7] Bertram, M. & Howard, L. (2006) 'Employment status and occupational care planning for people using mental health services'. Psychiatric Bulletin 30, 48-51

[8] Department of Health and Department of Work and Pensions (2016) Improving Lives The Work, Health and Disability Green Paper; NHS England (2019) NHS Long Term Plan

[9] Nomis Official Labour Market Statistics Labour Market Profile - Lambeth - accessed on 28/09/2021

[10] London Borough of Lambeth (2016) State of the Borough

[11] Office for National Statistics (2021) Employment Rates by Ethnicity

[12] South London and Maudsley NHS Foundation Trust (2021) Meeting the Public Sector Equality Duty at SLaM 2020/21 Lambeth ethnicity information

04

Aims and Objectives

Our original service evaluation proposal[13] stated that the aim of the project was:

> *to identify current issues relating to access to and quality of employment and vocational support, and the promotion of employment and vocational activity as an outcome, for SLaM service users and particularly Black service users. These findings will help us to work collaboratively with SLaM to develop changes to policy and practice that may be able to address these issues, and then test and evaluate these changes.*

As discussed in the introduction, the focus of our research became more narrow and specific as we developed our proposals. Through talking to Care Coordinators within SLaM's Lambeth community mental health teams, we wanted to gain a better understanding of the current situation from their perspective, including:

- the extent to which employment and other vocational activities/outcomes are seen as a priority within the day-to-day activity of these teams
- whether staff feel confident in their own ability to support service users around employment and other vocational activities/outcomes

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[13] The original service evaluation proposal is included as Appendix Four

- whether staff are aware of where else they can refer service users for support around these objectives and how frequently they make such referrals
- whether internal processes such as the Care Programme Approach (CPA), and wider policies and culture within SLaM, encourage and support staff to focus on these objectives
- what barriers staff felt stood in the way of more service users working towards and achieving these kind of objectives - at individual, service, trust and societal levels
- how the race and ethnicity of services users might shape their access to and experience of support around these objectives

It was hoped that, on the basis of evidence gathered from these discussions, we would be able to draw some broad conclusions about how effectively employment and other vocational activities/outcomes are supported within SLaM community teams, and what changes in policy and practice might help to improve the quality of support.

We focused first on how Care Coordinators perceived the provision of employment support for all service users, before narrowing down to a more specific focus on the intersection with race and ethnicity. Given the disproportionate rates of Black people and people from other minority ethnic groups in secondary mental health services, improvements to support around employment should, in turn, disproportionately benefit these groups. However, specific barriers, disadvantages and discrimination that these groups may face need to be accounted for.

05

Methods

Recruitment and Sample

Care Coordinators were recruited via promotion of the service evaluation to all the Lambeth community teams within SLaM. Emails were sent out to team managers asking them to encourage their Care Coordinators to participate, and presentations were made at a number of team meetings to directly appeal to Care Coordinators to participate.

A total of six Care Coordinators volunteered to take part. Three Care Coordinators had been in their current role for less than one year; three had been in post for between 18 months to three years. Three had a background in social work and others had nursing backgrounds. All were female. Three of the Care Coordinators were Black and three were White. They were from three different community teams within Lambeth.

Consent and GDPR

All interviewees were sent a participant information sheet ahead of the interviews, and were asked to provide verbal consent at the start of the interview to the questions listed at the end of this sheet. The participant information sheet is included as Appendix One.

The audio recordings of the interviews were saved securely and transcribed by an NHS approved transcription service. Recordings were deleted once transcribed and any personal identifiable information was removed from the transcripts. The transcripts were also stored and transferred securely.

Data Collection

Semi-structured interviews in July 2021 were used to obtain the perspectives of Care Coordinators working within Lambeth Community Mental Health Teams (CMHT). The main themes of the interview were:

- Perceptions of the Care Coordinator role: main duties, objectives, priorities and Key Performance Indicators (KPIs)
- Employment and vocational support: extent to which these feature in the Care Coordinator role, amount and quality of support they are able to offer to service users, barriers to support
- Care Programme Approach: perspectives on CPA and how it supports employment/vocational activity
- Race and ethnicity: how issues of race and ethnicity feature in their work, including service user experiences of mental health treatment and vocational support

The full interview guide is attached as Appendix Two.

Analysis

- We used the Framework approach to analysis.[14] Framework is a method for organising and synthesising qualitative interview data within a matrix. It allows for transparency and retrievability of data, making it particularly useful in team-based projects (Gale et al., 2013);[15] it is also well suited to applied policy-focused studies (Ritchie et al., 2003).[16]

The Framework method uses a coding 'index' to organise data under themes and subthemes. A preliminary index was developed, based closely on the interview guide headings. Two interviews were selected at random, and a researcher [AI] listened to the audio recordings in tandem with the transcripts, to confirm that the index was appropriate to the structure of the data. The finalised coding index can be found in Appendix Three.

The coding index was converted into a matrix, using Excel software. Each row of the matrix represented one participant and each column represented one theme. Data from each interview were then synthesised into the Excel matrix, using a combination of summary notes and verbatim quotations (a process known as 'charting' within the Framework approach). Transcripts were checked against the audio to ensure accuracy.

Using the Framework method to organise, condense and display the data enabled us to produce an uncomplicated and accessible synthesis of the dataset that could be shared and utilised across the project team.

A second stage of analysis involved a more fine-grained examination of the synthesised data. This level of analysis drew out, compared and contrasted the specific views and experiences reported within each indexed category, generating a set of main findings in relation to the study's core research questions.

Interpretation of the data

When interpreting the findings of this evaluation, it is important to bear in mind the small sample size. Data are not strictly representative nor generalisable. However, the themes presented below are reflective of known issues and experiences within community mental health teams more widely, across SLaM and nationally. The present data provide rich qualitative illustrations of these issues, thus supplementing other data sources that will be drawn on in the wider Black Thrive Lambeth Employment Project of which this evaluation forms a part.

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[14] Richie, J., Spencer, L. and O'Connor, W. (2003) Carrying out qualitative analysis. In: Richie, J. and Lewis, J. Eds., Qualitative Research Practice, Sage, London, pp.219-262.

[15] Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC Medical Research Methodology, 13(1), 117. doi:10.1186/1471-2288-13-117.

[16] Richie, J., Spencer, L. and O'Connor, W. (2003) Carrying out qualitative analysis. In: Richie, J. and Lewis, J. Eds., Qualitative Research Practice, Sage, London, pp.219-262.

06

Findings

1) Role, objectives, priorities

Attraction to the role

Care Coordinators gave a variety of reasons as to why they were attracted to the role. These included pragmatic reasons, such as the alignment with their previous roles or fit with personal caring commitments. Yet for many there was also an attraction to engaging in a more holistic form of support for service users, that was longer term and involved more relationship building and social support beyond a narrowly medical focus.

Role of the Care Coordinator

There was a common view among Care Coordinators that the role is very wide ranging and can involve a diverse range of activities and support for service users. These included: crisis management, medication management, monitoring/stabilising mental health, psychological support, physical health, social welfare and practical support, e.g. around housing, benefits or immigration. One Care Coordinator described the role as “multi-layered and very extensive” whilst two others described themselves as a “jack of all trades”. The breadth and diversity of the role meant that it could be difficult to define succinctly:

> *I think the fact that it's so undefined is an issue and I think you can range sometimes from being a person's PA, you know, you can be doing tasks or helping somebody order a washing machine or making sure that they are getting their COVID vaccine, or you could then be delivering a bit of psychological intervention, or supporting them to go to a group or talking to them about medication. You kind of feel like a bit of a jack of all trades and master of none sometimes*

> *We are meeting particularly lots of young people who have a lot of care and support needs. They may have been in hospital, they have been referred by their GP, but there are sort of immense amounts of layers of support that they may need. It is not just about thinking about their mental health. Obviously that is the fundamental issue we are trying to support them with, but a huge part of their recovery is considering how they want to get their life back on track, and as a Care Coordinator that is what you are trying to explore with them, and trying to put in place everything that you can, all the support that you can get them, to try to support them to live the life they want to lead. So I think a lot falls into the Care Coordinator role, that sort of spans out from that*

Whilst the variety inherent in the role was a source of interest and enjoyment for some Care Coordinators, one Care Coordinator with a nursing background described how the role was not quite as she had expected, and that the expectation to provide a wider range of more social support was something she found challenging:

> *How I understood it and what I am doing now is different. It's not much different but there is more to it. I understood it as a Care Coordinator I am essentially coordinating care for the individual who has needs. So this care can come from wherever, consultant psychology input. I didn't know I had to be adding social work to it as well. I do see doing loads of social stuff as well as in supporting them with housing. Even when you are just liaising with the housing officers, they are not doing much, so you are doing a lot of that than actually the medical part. As qualified as a nurse, I was more into the medical part whereby I know I am just going to give my patient depot, I know I will talk to my patient for their wellbeing and I will signpost them. I knew about the signposting but I didn't know I would be doing- 50% of my job will be doing, as one of my colleagues would describe, being a housing officer really, you know. So yeah that bit I find it really tough … It's a distraction, a big-time distraction, I would say, from what I am supposed to be doing really, and that's the bit I don't like about it*

As well as affecting job satisfaction, one Care Coordinator noted that this lack of role clarity could also be a challenge in terms of managing service user expectations:

> *Sometimes I wonder whether if there was more definition and we did maybe go back to more of our kind of professional roles, people might be happier in the job. There might be a few more boundaries and it would be a bit clearer for the people who use our service, about what they can expect from us*

How professional background shapes approach to role

Care Coordinators with social work backgrounds perceived that the ethos of their training drew them towards a more holistic approach to service user support, and that this was part of the appeal of the role. They felt that, as compared to their colleagues with nursing or Occupational Therapy (OT) backgrounds, those with social work training expected and embraced the holistic nature of the role, were open to getting involved in a wider range of social support and were somewhat less boundaried in their approach to the role:

> *This is not to say anything bad about nurses, you know, I've worked along with some excellent nurses. But… I don't know if it's to do with the training or to do with the ...ethos and ethics around social work - I just feel that we maybe have a bit more of a flexible approach. And though I might be moaning about helping somebody get a washing machine or trying to help somebody access housing benefits or, you know, the little things like that, I can see the impact that can possibly have on somebody's mental health. And I think maybe...I'm more kind of motivated by that like social - and inevitably political - approach to people's mental well-being ... I think I might be told by my managers that I shouldn't be doing X, Y and Z, but my own kind of moral stance on it is that actually I can see that this might benefit somebody, and if I don't do it then who will be supporting them?*

> *I think they (nurses and OTs) are sometimes maybe more surprised at the whole range of things that are involved. And actually things like benefits and immigration etc I quite like helping people with. You know, there are some discussions about, oh, you know "Care Coordinators are doing too much of this or that"… "We are all meant to be… helping with their mental health, primarily". But I think… in social work where we are trying to look at things all holistically, and in the system and all of that, that that actually should be- feels like it should be a big part of it. But equally it is time consuming, so I guess, yeah, I can see why some people don't really want to be doing it*

> *Someone who trained in Social Work may have a different take on the Care Coordinator role than someone who has trained maybe as an OT or trained in nursing. And again this is just a personal observation of working with colleagues and a multidisciplinary team. As a social worker I think a huge objective for me is seeing the big picture and seeing people as individuals*

Given the potential breadth of the role, and the different backgrounds and preferences brought by Care Coordinators, it was recognised that the role could be approached in different ways, with some Care Coordinators taking a "bare minimum" approach to the role, and others embracing and enjoying getting involved in a more holistic range of social support, e.g. housing, immigration, benefits and employment. Whilst this study sample is too small to generalise from, there was some indication that those with nursing backgrounds perceived a more predominantly medical focus to their remit, and could find the expectation to cover a broad range of social supports somewhat challenging.

Priorities of the role and influence of KPIs

Care Coordinators understood their service to be primarily focused on risk management, medication and stabilisation of symptoms, psychological intervention and health checks - all of which were underpinned and driven by associated Key Performance Indicators (KPIs).

Regular fulfilment and reporting of KPIs was felt to be very time consuming:

> *For management... it's all about KPIs, make sure your KPIs are on top, make sure everything is done, the paperwork is… too much. So let's say I've had contact with a patient, I know I have to put down my notes, but there's other things that come into it, so it's not just a quick note as in, "Oh, contact this person, they are well, they expressed this concern". There is more to it as well, you know. Your managers or team leaders are.. on our KPIs every week; it was two weekly, now it's changed to weekly and we're having to give our time as well... time to make sure… your KPIs are 100%*

> *Every year, ideally more regularly, we are meant to be kind of reviewing people's care plans with them, but that is also making sure their risk assessments are up to date and their child risk and their physical health screen and their drug and alcohol screen, which yeah are all really important, but there is definitely a focus on getting all of that paperwork done, which is very time consuming*

There was some evidence of slight tensions between what some Care Coordinators personally saw as the most important or impactful aspects of their work, and what was prioritised and measured by KPIs. For example, regarding time-bound KPI targets, one Care Coordinator commented: “In terms of like monitoring how people- I don’t personally see how that informs how well I am doing as a care coordinator or even like a person’s recovery”.

Another Care Coordinator reflected on the inefficiency of some of the assessment tools and IT systems used within SLaM, which meant that time with service users was sometimes not used in the most productive or valuable way:

> *It is forcing you to use your time in a way where you feel like you are using the time to satisfy SLaM’s requirements for documentation, but that is not being translated into meaningful time for that service user. It is almost like you are making a choice, when it shouldn’t be. Because the whole point is that those two objectives should be combined and meshed together, so that that questionnaire or that time spent is always feeling like it is meaningful and working in the interests of your service user, not diverting you away. I mean we all know we have got to do KPIs and that they are relevant, but I think there are better ways to ensure how you are documenting things. You can streamline things, you can get a better computer system where you know it just frees up a Care Coordinator to do things in a different way*

Some Care Coordinators felt that service priorities that centred around meeting criteria and timeframes for KPIs detracted from time available for more (psycho)socially-focused support. The service as a whole was felt, by some, to place lower priority on more holistic social support activities that Care Coordinators may undertake:

> *I think there is also a bit of a culture of… if people are in supported accommodation, a lot of those things that we might see as extra - so you know, supporting people with PIP and benefits and, a lot of the time, Leave to Remain applications - that that should really be down to the people who are working in the supported accommodation. It’s not to say that stuff like relationship building isn’t prioritised; it’s just it’s not spoken about as much. Because it’s just this constant, are we getting the paperwork and those medical reviews and physical health checks done within those time periods really*

> *I mean we are very focused, obviously, on someone’s mental health and physical health, and there is a real push at the moment to measure those things in KPIs and outcome measures. Do I feel that other things that are possibly just as important to our service users - like getting a job, getting access to courses or training - is valued or measured as much? No, I do not, and I think that it could be*

However, reflecting the variety of backgrounds and perspectives held by Care Coordinators (as outlined above), there were some who did perceive that medication management and the stabilisation of symptoms were rightly the predominant focus of their role:

> “ *So mostly, first things first is management of medication and their treatment. So an outline of their treatment, what medication they are on and how their treatment plan looks like. So if they are having psychology or any extra things like just making sure that everything is tailored to them and that they're making the correct steps following through their care plan and making the correct steps on the path of discharge*

There was also an appreciation that the pressure to prioritise KPIs came from a higher level - that local team leaders and line managers appreciated the tensions and workload pressures of Care Coordinators but were pulled by pressures or targets from above. “Political” or managerial issues such as bed management could take priority for services, with an impact on CMHTs e.g. when people were discharged into the community before they are ready:

> “ *I think the needs of the organisation sometimes outweighs the needs of the patients and... I mean, bed management, bed stays, like you know, like in terms of hospital stay and stuff like that. Like because of pressures from management they will discharge people that are not ready. They don't communicate- they won't communicate with us, the community team, that they have discharged this person and they have discharged them into the community. We then have to find out later on, or they have put them up in a hotel and you know, they are at risk. But because a bed is needed or they need to fill beds or, you know, things are not properly followed through*

The Dialogue Questionnaire was mentioned by one Care Coordinator as one of the more useful things that fell within KPIs, as it was a helpful tool for facilitating discussion with service users. However, this Care Coordinator felt that Dialogue was one of the most neglected KPIs - mainly due to time constraints.

Caseloads

There was a view from all Care Coordinators that caseloads had risen dramatically in recent times, and were increasingly difficult to manage. Whilst there were differences in what Care Coordinators said was their intended caseload size, they typically had significantly more than the expected maximum. For example, where caseloads should be around 30, it was not uncommon for Care Coordinators to have around 40-45 on caseload, or where the expectation was 15, a Care Coordinator had a caseload of 25-30.

High caseloads, and the associated influence of KPIs as a measure of their work, were felt to be key factors preventing a greater focus on social and vocational support, and a negative impact on the depth and quality of care more generally:

> *It´s getting increasingly more difficult to have the space and time to be having those conversations with people and supporting them with some of the things we might identify, because the caseloads are just getting higher and it only takes one crisis to kind of take up your week really, and then you are sort of forever playing catch up*

> *Sometimes it just doesn´t really feel like we have the time or space in reality to be sitting down and having those kind of sessions with people, like the kind of therapeutic or like psychologically-led tasks. And bearing in mind our psychology has like a year waiting list or so, it would be helpful for us to be able to do some of those things with people at least while they are waiting...like the community organisations and social inclusion activities and employment and that kind of thing, I think I´m probably just referring people onto things a lot of the time. And trying to go with people to things like that for their first time, but then not always feeling like I have the time to actually do that, even though that could be beneficial or might make people more likely to go*

> *My caseload is a lot. I started from 25 when I came into the team because I took over one of the Care Coordinators leaving and I ended up with 47 … And I can´t cope, I really cannot cope. I just don´t know how it turned from 25 to 47, and that´s within the last two months or three months… So I had to have supervision and say you know I can´t, because I am missing stuff, I´m missing- the patients that I have tried to stabilise they are right at the back of the queue. They are becoming unwell because obviously I am not giving that kind of care that they need me to give - or I was giving to them before*

Covid-19 had further increased pressure on CMHTs as they had remained open when other healthcare services were closed. In addition, there had been higher levels of staff absence due to stress or anxiety, and a recognition that staff wellbeing has been suffering over the past 18 months. This sense of “firefighting” further reduced the amount of time that could be devoted to wider social support for service users.

> *There is an impact of people going off sick because of stress and anxiety - probably linked to Covid or linked to the increased workload - so that has affected us… you get that sort of compound effect... And all of that means that you feel you are sort of firefighting a little bit. I mean for example, I am getting... sometimes a new patient a week... I am not saying it is always like that, but that is maybe because our particular service is just getting more and more referrals - that really does impact the way that you are working with people. And you are wanting to do more in-depth quality work and really sit down and drill down with them - what they really want, what they really need, and it can be more difficult to give those services users the time that you want to give them, because your caseload is growing and you have got another assessment to do… And whilst it is acknowledged in SLaM that the last… 16 to 17 months have been really difficult, you are still expected to keep doing the role and keep on accepting more and more patients… I mean I know that is a universal problem for lots of services, but… there are different ways of managing that. But then that is going to lead to your focus becoming absolutely about checking in with them - is their mental health stable, you are assessing the risk, physical health etc, but then when you are looking at those what I consider, or others consider, maybe the peripheral additional things like... referring them to community organisations and working on the extra stuff like not just staying well. But, you know, getting a job or all of that kind of stuff, it becomes less important just because you are having to cover your basics first, with...a much higher caseload and it can be more difficult to give those services users the time that you want to give them, because your caseload is growing and you have got another assessment to do… And whilst it is acknowledged in SLaM that the last… 16 to 17 months have been really difficult, you are still expected to keep doing the role and keep on accepting more and more patients… I mean I know that is a universal problem for lots of services, but… there are different ways of managing that. But then that is going to lead to your focus becoming absolutely about checking in with them - is their mental health stable, you are assessing the risk, physical health etc, but then when you are looking at those what I consider, or others consider, maybe the peripheral additional things like... referring them to community organisations and working on the extra stuff like not just staying well. But, you know, getting a job or all of that kind of stuff, it becomes less important just because you are having to cover your basics first, with...a much higher caseload*

> *I just think we obviously need more resources to split up the teams in terms of like referrals and that, where we are getting heavy caseloads. And it needs to be less politics and more patient care... And having staff wellbeing. Especially looking at the last two years of Covid, we need to really put our staff first more than anything. I mean if you do not have staff, you cannot have staff to look after the patients, do you know what I mean? So staff health and staff needs really needs to be at the focus of every organisation because you need us at the end of the day for everything to run and so staff need to feel protected, supported and encouraged and motivated to give out the best that they can give for the organisation*

Key elements of recovery

Some Care Coordinators described recovery in terms of a purposeful, enjoyable, socially connected and fulfilled life - a life that is “back on track”. There was recognition that this fulfilled life will look different for different people:

> *I think it’s something that has always stuck with me, the idea that kind of psychological wellbeing is made up of doing things that give you purpose, things that give you- I say things but you know, not material things, but activities or stuff that makes you feel that you get pleasure from, that you get enjoyment from, and things that give you some form of social connection. So if I’m approaching the idea of supporting somebody with recovery, and I suppose in this context, recovery from an episode of psychosis, those would be the kind of three areas that I would be asking the people I work with about, and obviously you kind of can take specifics from that. Purpose, you know, in this capitalist society tends to come from work, doesn’t it, but yeah, or like a kind of sense of routine. And I have had some interesting conversations with people about that, about what gives them that sense of purpose. So yeah, for me that would be the kind of, the three elements that I would be looking at, but obviously it’s subjective*

> *Whatever recovery is for that person it has to be personal, it has to be individual so every single time I assess and meet a new service user who is allocated to me I am thinking very carefully about what is most relevant for them. Of course I am going to take them through everything that my service can offer because the (this) service in particular does try to offer I think more than just a general CMHT. But it is about working with them to establish what it is that they think is going to support their mental health, and - as I say - that large objective of helping them to get back on track of you know living the life that they want to lead where they are both mentally well and stable, but also living a valuable and you know happy fruitful life*

Other Care Coordinators talked more in terms of recovery as indicated by discharge from the service, and that being a sustained discharge rather than a revolving door. Readiness for discharge would be indicated by things like having an understanding of one's condition and having good self-management of medication, but also a stable housing and financial situation and overall "better quality of life" as compared to when the person was admitted:

> *Have like an identified discharge date, so you know what you are working towards. Having an outline of the service, what the service can provide, what can be provided for you to help you and understanding of one's own condition and treatment. Reasonable and clear resources around them, that they can access. I think the most important thing to recovery is to always have discharge in the middle, at hand, so you know that, yeah, you know, I'm working towards discharge, I'm working towards recovery. And you need achievable goals and future plans as well to have something in sight … If it's about to come to an end, you know, how will they manage. Will there be a follow on from that. Their social situation so that could be their housing and their finances. How they have managed from admission until now. So someone's now got regular income, manages their money well to pay their bills and stuff, not homeless or anything like that and, you know, they are living a better quality of life compared to when they were admitted on our waiting list. So that would look like a really good discharge*

One Care Coordinator described how the key to achieving recovery is plenty of time for 1-1support and time to keep close contact with service users, so as to monitor and quickly respond to any change in their progress:

> *Having loads of… hands-on support whereby you have the one to one… they do like that one to one. So when you- let's say I am contacting a patient monthly or let's say every three weeks because of their risk, if I keep this three weeks going, I know when they are relapsing. I know- I can tell, maybe the way they are sounding on the phone, maybe them avoiding to engage, because we do know about their relapse indicators. So if I am keeping an eye and I am constantly contacting this person I think it helps and the support can come in place quicker than them relapsing completely and going into hospital. So do you understand? So I think, yeah it helps with their recovery. I can quickly book a medical review and send it to the consultant: I think this person is relapsing, this and that about the indicators and can you see them. And they can see them, they can change medication, they can you know, put things in place*

However, high caseloads could mean insufficient time for this close contact or monitoring, increasing the likelihood of relapse/revolving door.

CPA process

The Care Programme Approach (CPA) was intended to ensure that people who needed more intensive mental health support had a Care Plan - which was supposed to be designed in partnership with them and reviewed regularly - and a Care Coordinator to help deliver this. The CPA has now been replaced with the Community Mental Health Framework, which sets out minimum expected standards of care for all service users, not just those who would have previously been on the CPA. There was a mixed response to the question of how helpful the CPA process is, in terms of asking people about employment and identifying any support needed for more vocational objectives. Some Care Coordinators felt it was beneficial to have a specific place or process to record what they would be working on with the person they are supporting:

> *Yes. I would say it is helpful yes. At least you get to know what the person wants, do you understand? It makes your work a bit easier because you are able to support them that way. You are able to, how do you call it, joint work as well so you have a lot of joint work which is good. To me it's- I don't feel alone as a Care Coordinator, if there's- with the CPA process in place, I know kind of how to help the patient, so I think it is helpful. I think having that CPA approach is helpful*

> *It is very important so people have an outline of their care and stuff like that and have something to, you know, look at to see their progress and things like that*

However, other Care Coordinators suggested that the actual CPA meetings didn't add much to the support they were providing to people and are seen as something of a formality:

> *Quite often it feels like we are doing medical reviews and calling them a CPA and then just filling in all the paperwork that goes alongside it*

> *It's not a very formalised process. I don't know that people are actually doing CPA reviews. One thing I think is really good in the team is like the access to doctors, like people have really regular reviews with a doctor and we tend to just record, you know, one of them as a CPA review but in terms of having that formal - and I do think Covid has really affected this - but yeah in terms of having like those reviews with everybody that's involved in your care, I don't think that is happening that often, so it's hard to say whether the people we are supporting are like benefiting from that. I think informally the team is really- like we work really well together, have really good working relationships with like the psychologists and the doctors in the team. But whether that's actually being felt by the people that we support, I don't know*

> *Does a service user know what a CPA process is? Probably not. Do they care? Probably not, it is just another meeting to them. Does it help them? Does it progress their aims, probably not? So I know it is something that we all, you know it is a system we all need to know and work within, but in terms of its relevance and how that translates to what is happening for the service user, no, I don't think so. I think that the fundamentals in that the CPA process and why someone is under CPA you know are, should be absorbed anyway to Care Coordinators and it is relevant to all the work that you do, but I just think it is another label, but I do not think it makes you work in a different way, certainly it does not make me work in a different way. Yes I know that we are meant to record it on a system as to whether it is a CPA review meeting or not, but I know for sure that for a service user and someone being care coordinated it would not make a blind bit of difference. What they care about is the tangible support that they are getting and that time with you - is it translating into anything meaningful to them, both in terms of that emotional support, both in terms of helping them to achieve their goals, that is all they care about*

There was a similarly mixed response when the Care Coordinators were asked about whether employment as a potential objective, and the support needed to achieve this, comes up in CPA reviews. Where this was happening, it seemed to be down to whether it was raised by a professional or a service user, rather than due to the CPA process prompting it:

> *No, it does not prompt me to do anything. CPA would not prompt me to do that, that is you know prompted by my conversation. My personal bespoke interactions and engagements with my service user. If at the beginning that is set out as an objective then that is what we are going to look at and that is what we are going to focus on.*
>
> *CPA does not come into it, from my perspective*

Similarly, a number of Care Coordinators said that things like employment and benefits status are not collected as standard as part of the CPA or other formal processes, and aren't easily retrievable from the electronic Patient Journey System (ePJS) (SLaM's version of "Care Notes"), but often would be recorded within day-to-day notes.

2) Employment

Prioritisation of employment by teams and by the service overall

The different teams from which our sample was drawn had different arrangements in terms of whether they had dedicated employment support staff. Some teams had a vocational worker, some had an IPS worker, and others had no dedicated employment support staff.

There seemed to be a perspective that whilst the existence of dedicated staff in theory demonstrates that employment is seen as a priority within some teams, in practice these members of staff have fairly limited capacity, compared to potential demand. More staffing resource dedicated to employment support would reflect a more genuine prioritisation, and would allow for a more consistent and reliable support offer:

> *Just the very fact that our vocational worker is super busy suggests that we are at least, you know, making those referrals. But from maybe a bit of a large- higher up perspective, if it was so much of a priority we would probably have more than one vocational worker in the team*

> *I would imagine that SLaM thinks because we offer a specific subteam within our service they would say, you know, that is the very best way to highlight this work and to prioritise it. And on one level that is true, as long as they are checking and reassured that that is working within our subteam, but if it is not working and functioning properly that should not be allowed to stagger on. Because as I said, I think it is such a fundamental intervention that we offer and it needs to be done properly, it needs to be done well. You could change the course and the trajectory of someone's life if we can get them to access some kind of course, or you know something that fits in with how they want to live their life. You could change everything for them. And that is how I see vocational support, this is an opportunity whereas before you are flailing around and not feeling able to connect up and access so here is the opportunity, you have been in a crisis, you are now under our team, here is something really wonderful that we can do for you, but that has to be followed up with a really well functioning service and if it is not functioning well it is a massive missed opportunity, but it is just so disappointing and undermining as a Care Coordinator. And you know for our service I think it is a big fail. So I think SLaM thinks it is probably covered because we have got a subteam, but I think that they need to go a bit further to be absolutely sure and monitor is that service working and also obviously we need to be connecting up with other kinds of services as well, in the community that can offer that kind of support*

Medication management, therapy and other KPIs are given priority and take up a lot of Care Coordinators' time:

> *I do think (Care Coordinators) see that as important, but I think it's because they have so much to do. They have so much to do, I think that is like on the back burner*

Hence, overall, it did not feel to Care Coordinators as if vocational outcomes are given particularly high priority at a service level. The semblance of support for employment and vocational activity is in practice not really borne out to a great extent:

> *I don't think it's a priority, as I said before…I think it's about treating the patient's mental health, ensuring that they're stable, ensuring they're taking their medication, ensuring that they're doing their blood tests, to ensure that the, you know, the therapeutic level of the medication is okay. I think that is the main focus*

Care Coordinators agreed that employment should be give more priority than it is at present, with one suggesting that introducing an employment support offer earlier in service engagement might be beneficial:

> *I suppose (employment support) is there on like our menu of interventions; I think something that we're quite, you know, quite proud that we have people, two dedicated members of staff in the team that are around employment. But I am wondering, I suppose, one thing that's happening in the team is what we're starting to do now is when somebody is accepted onto our team - so when they've had their initial assessment and we have said yes, they're for (this team) - pretty much straight away psychology will do a triage assessment and that is- and then it is decided what kind of therapy would be best for them and we have got loads of low intervention modules and groups that people can access during the waiting time. I wonder if we maybe introduced it at the start, in that same fashion, that maybe that would I suppose introduce it like sooner in a person's kind of- hopefully their recovery journey with (this team). Also might make us feel a bit more confident in kind of bringing it up a bit more in the sessions and maybe yeah, maybe it just becomes more of an established way of doing things*

> *I don't think people do it enough, but ones that do do it find that, you know, people actually do want to work. It is just about tailoring and finding out what kind of work they will be good at. Because some patients actually work, you know, and some don't and it's definitely something to boost up one's confidence*

> *I think most of the patients are usually very unwell when they come to us and those who are stable enough, I don't know, I think- I don't think it's been a priority, but it should be. It would be good to have people in employment, you know, sustainable employment and I think, yeah that would even help them better as well. Their own wellbeing and mental health as well*

There were also suggestions that SLaM as a whole could be doing more to actively lead on this agenda, both in terms of prioritisation and strategic action:

> *Maybe it needs to be talked about more from above, from the top, you know, it needs to be because most of the things come from the top really. So if it's encouraged from the top then yeah*

> *I don't know whether SLaM could take a bit more of an active or a leading role in having more of a vision of how we can get people into employment, having actual placements for people, more opportunities for people to actually get into work and more advice and support for staff when we are like, if we were to be interacting with employers, and kind of reassuring employers or giving them the information that they need*

Prioritisation of employment by Care Coordinators

At the frontline level of care coordination, most Care Coordinators felt that employment is given more of a priority. Care Coordinators see the value of employment and most tend to at least raise it in conversations with service users. Despite seeing it as important, Care Coordinators feel constrained in their ability to prioritise employment due to other demands of their role (high caseloads, KPIs).

Care Coordinators agreed that employment is usually raised in the course of the CPA process, with at least some record being made in the care plan of a service user's benefits and employment status. However, Care Coordinators said that this tended to be fairly brief notes rather than a full exploration. One Care Coordinator emphasised that the CPA isn't necessarily the driver of these discussions - employment is something they would raise and explore in any case, as they see it as centrally important.

One Care Coordinator noted that the offer of employment support can be a useful hook with which to engage service users who are perhaps reluctant to acknowledge a need for mental health services:

> *Some people are struggling with this idea that they have not been well, but what they can engage with and talk about is something that appeals in terms of feeling tangible, feeling real for them, and not just talking about mental health*

> *It is interesting that when you run down that list with different service users, obviously you are going to get a different response, but often - particularly young people coming to our service - it is something that they are really, really focused on and really wanting. And in fact I would say sometimes it is the reason why they will agree to engage with our service. I think this is the reason why the gentleman I have just mentioned is prepared to engage with our service because he was very ambivalent, so I have used that as a way to get him to come in… and to somehow influence and persuade him that we can be helpful to him. Trying not to just focus on medication or psychology or those things that you know he is struggling with right now. Because he is struggling with accepting that he has had a mental health crisis, but what we can talk about and he really wants to talk about is the vocational side of things. So, you know, it is all relevant and… you have got to offer and explore the things that people want*

Past work experiences are explored by some Care Coordinators, where relevant (some young people don't have a work history as such), and Care Coordinators will try and help service users to think through current plans in relation to past experiences, preferences, or goals. In one Care Coordinator's experience, service users often raised employment themselves, and had ideas of what they would like to do:

> *I feel that a lot of them, like a lot of them, that is people come up with that goal themselves - that is what they would like to be doing, even if they are maybe not like at the place where they are totally ready for it yet. But I think that's- yeah, is a conversation that we- yeah, that I have with people*

In contrast, another Care Coordinator felt that - despite opening up the discussion - people on their caseload were generally disinclined to look towards employment:

> *I do ask them their previous experience, what they would like to do next, if they would like to return to the same job or, not the same place but the same thing they were doing before, and stuff like that. So we do talk a lot about employment but I have noticed most of our patients do not want to go back to employment, even the younger ones*

It was noted that what people did before might not be appropriate or manageable now. For some people, it might be a good time to revive a dormant interest or pursue a long-held dream, or to try something new. But one Care Coordinator noted the need to weigh up encouraging people to pursue dreams (e.g. in creative industries) versus sticking with something more stable and less competitive and demanding.

There was also a view that the Early Onset Team tends to work with younger people, and hence is potentially more focused on employment than other CMHTs with older clients.

Perceptions of own ability to support

The overall view seemed to be that Care Coordinators are open and willing to initiate a conversation about vocational activity or employment and to explore service users' wishes, needs and barriers. They will also signpost to vocational support services where they are aware of these, but feel less confident about their ability to offer direct employment support. Care Coordinators therefore value the availability of specialist vocational workers, refer to the in-house specialists regularly, and feel that it would be valuable to have more vocational staff, or greater capacity within the team. However, there was some uncertainty about what support was available and how best to support someone to navigate this:

> *I guess I don't feel that equipped to be honest. Yeah, I do tend to try and involve people that have more expertise and frustratingly at the moment it feels like we don't have enough of that in the team. Even having one IPS worker and one vocational worker, I still don't really think it's probably enough for the number of people that we have got, and the number of people that are interested in - if not in employment - like getting there and getting the skills that they need to get there. So yeah I mean in terms of advice, I guess having just conversations about what people would like to do, what they have done, what they feel you know the barriers are or what skills they feel they would need to get there, but yeah I guess trying to involve others a lot*

> *I mean I have got my support worker so if there is any kind of, you know, resources out there like if one of my patients says, "I want to do this", I will always go to them. So it's really, if they are equipped with all the information then, yeah, everything is sorted. So you know, if we can find more information, more links about certain things that are out there we can signpost our patients perfectly… 'Cos there are loads of things that are going on that we all don't know about*

> *I'm not well equipped because I've only got two services that I refer clients to. It's not as if I actively look over their resumé and to then show that it's up to par. What I tend to do is refer them on to other services*

> *I would say no (I don't feel well equipped to support), because I am not sure, like, with the different things you can do to help, getting someone back to employment. Because I know the signposting, there's loads of signposting around and- but for me to actively say okay there's a job here, yeah that I know I will speak to someone that can help, do you understand, it's a bit- yeah it's out of my depth a bit*

> “ *I think that I would feel more comfortable, first of all, if I felt that we had a more solid pathway and I understood that more as a Care Coordinator, so I could provide details on it as to when I refer somebody to, you know, a professional who is meant to give them vocational support, and if I understand - after they have had that meeting - what is going to happen next. And that has been a little bit hazy on my team and again I don't know, because it is maybe a little political and a little bit sensitive as to whether that is due to the individuals who are working in the subteam, or whether the way that is set up in my particular service, I don't know*

One Care Coordinator talked about their concerns around giving ‘advice’, as a non- expert. Hence they took more of a coaching and motivational interviewing approach, rather than direct advice:

> “ *I suppose I feel a little bit anxious myself about maybe giving out advice that is- because they are big decisions to make and it's not like you're just advising a friend is it, you're- you know, someone you have a, yeah, duty of care towards ... I mean I guess in some ways a lot of it is kind of like motivational interviewing isn't it and trying to sort of, I guess encourage people to kind of come to those conclusions themselves by asking the sort of right questions. So maybe if I approached it that way. But I don't feel- I wonder whether I am the right person to do it*

Time constraints also meant that Care Coordinators couldn’t offer as much hands-on support as they would like to, e.g. accompanying clients to activities or appointments:

> “ *I think when the caseloads are considerably higher than they should be, you end up focusing on I guess the priorities that we were speaking about in the beginning with KPIs and so on because, and you know the more urgent and crisis and firefighting because, well obviously you need to be tackling the urgent things, but in terms of KPIs etc you know that there is going to be some kind of negative outcome or you know we are all going to get a ticking off if those things don't happen, so you end up spending your time making sure those- That then feels like the basics and the bits that needs to be done, so you end up doing those as the basics rather than focusing on some of the longer term things that you might like to be doing, you know like employment, like other social inclusion activities, like just having more, even just more head space to kind of reflect on some of the cases and what might be helpful for them in the long term. You just feel like I'm booking the next thing in and then I'm there and I haven't really thought about what- well that is not quite true, but you know I haven't spent as much time thinking about what I would like to be doing in that session or how to make it most useful and then you are just kind of going onto the next thing and onto the next thing*

One Care Coordinator noted the issue that once people are in employment, it becomes difficult to support them, because they are in work (hence unavailable during the Care Coordinator's working hours):

> “ *Something that is quite interesting is that when people do go into employment, it becomes increasingly difficult to support them because they are working from 9.00 to 5.00, and our service, you know, that's when we work, so that's another thing*

Service user readiness for employment

Service users are in a variety of places with regards to employment, when they engage with the service. Some are already in employment (and are able to work successfully, when they are well); others are a very long way from employment. Some Care Coordinators saw the latter as in the majority. One Care Coordinator with a nursing background was quite notable in their view that most service users are not in a position to consider employment at the time they come into the service:

> “ *I don't know other people's caseload and where their patients are at, at that moment, but with me I find that my patients are mostly unwell to even discuss employment, do you understand? So yeah at some point, yeah, so it could be where the patient is at. And I do have loads of patients that have passed the age of employment as well so they are obviously things that you wouldn't suggest employment to them. We do suggest maybe voluntary they are saying they are bored, there's nothing they wanna- they can do and yeah, we do signpost that but I don't have much younger people or- yeah. And because of the psychotic presentation, you wouldn't even suggest employment, because you know they are very unwell... It's not a priority I would say, with the kind of job and the kind of patients we have*

> “ *We talk about employment a lot with people. Some of them will say, “Oh I am not ready”. There's a lot of reluctance around going back to work. It could be their anxiety, it could be because they have been out of work for a long time, they don't know how to socialise with people, socialise when they get back to work so there is a lot of anxiety around that. But we talk about employment a lot*

Other Care Coordinators perceived that people on their caseload were more varied in terms of their readiness for work:

> *I feel like the people on my caseload kind of fall into three camps. I've got quite a few people on my caseload who are in employment and doing quite well, and we just sort of maybe talk about how things are going and managing things at work. And another few people who are kind of actively looking for work but have declined support from our vocational or IPS worker, and again I will just keep checking in with them but they want to kind of do that independently. And then some people on my caseload who just, either they don't feel ready to, or just not at that stage where it's appropriate to even really be having those conversations because there's kind of more pressing needs*

Notably, the Care Coordinator quote above perceived a group of service users who are quite work-ready but don't want Care Coordinator support; in this Care Coordinator's experience service users often declined the offer of a referral to the vocational worker, perhaps due to a sense of overwhelm of involved parties:

> *A lot of people that I work with decline a referral. And I wonder if it sometimes does just feel like, "Oh, it's another person involved", like you know," I'm seeing - speaking to (own name) every three weeks or fortnight or whatever and this will be another person". So that's what I mean; I tend to have people that are either like independently searching for work and don't want to, or just don't want to be looking for work at the moment*

This issue seems noteworthy and possibly something to explore in a follow up study with service users and providers. Another key factor that came up was people's age and how long they had been away from work:

> *Particularly I would say yes it is people who are in their twenties, I would say, who are most interested in exploring either courses or some kind of way of accessing work, or just something to get them trained up, you know, and that is part of their own goals really and I think they are at a point where they are ready and willing to do that. Whereas if you have been in contact with mental health services for a while, or if you have been unwell for a while, whether supported or not, it might mean that you know looking for a job or looking for courses to skill, you know upskill yourself is less of a priority*

Linked to this, there were suggestions that not only being unwell but also being in services for a long time, and the mindset this might create, limits people's ability to consider and move towards employment:

> *I guess some of them have been quite unwell and maybe... they've been in hospital and just everything has changed for them a lot and you know their routine- everything is just different for them now and they feel that they would like to go back to employment but it is just going to take some time to- for that not to be too much for them, if that makes sense. And a few of those people that I am thinking of where they're- like maybe they've tried to- or trying some volunteering or they're maybe starting some courses and things like that, but actually being in employment...they're not there yet*

> *Some people are very used to being sick, being in this sick role and they can't- they can't break it. Some people lack the information, the resources around them and some people, they're just too unwell to work, both mental and physical*

Another important point raised was the impact of medication on people's ability to work:

> *I think obviously medication can be a barrier, like for quite a few people when we start working with them they've come out of hospital and they might be on olanzapine and pretty drowsy and so I think sometimes we have to- it takes us a bit of time to get the medication onto like a stable dose which works for people*

Quality of in-house vocational support

Several Care Coordinators commented that their vocational worker is highly utilised - and indeed over-stretched. Care Coordinators in the Early Onset Team were all aware of the vocational worker and IPS worker, and made frequent referrals to them. Absences and some perceived performance issues among the vocational team had impacted the amount and quality of vocational support for service users over the past 12 months. There was a feeling that the referral pathway was not very reliable or effective at present.

There was a common view that greater resourcing (staffing, capacity) of in-house vocational specialists would be valuable:

> *Frustratingly at the moment it feels like we don't have enough of that in the team. Even having one IPS worker and one vocational worker, I still don't really think it's probably, you know it's probably not enough for the number of people that we have got, and the number of people that are interested in - if not in employment - like getting there and getting the skills that they need to get there*

One Care Coordinator commented on how the vocational worker seemed to provide more appropriate support for service users who were still some distance from work, as compared to the more immediate employment focus of the IPS service:

> *I think that is what I struggle with a little bit, is like okay, well if work is too much for them, what can we look at? And I think that is where a vocational worker comes in handy... I think the idea is that they work with people for a specific number of sessions and I think it can involve- I think it can be a combination of having those like motivational conversations around helping people to identify the things that they’d be interested in and then also linking them to different things that are going on in the community and education. So I think there is the opportunity for, it doesn’t necessarily just have to be- like I know that IPS is quite structured and the idea is that you are meant to be already looking for employment within four weeks or something like that, I’m not quite sure what the- again I feel that is quite like target and KPI heavy. Whereas I think this vocational support worker it’s more of like a- not so maybe like results driven. But I might be wrong I don’t quite know that much about it*

There seemed to be a general consensus that more in-house capacity to support service users around employment and other vocational outcomes would be beneficial:

> *I think it would make a huge difference if we had more support workers in the team... There are some people on my caseload that I can identify that maybe they would give things a go if maybe just for the first couple of sessions, somebody would be able to go with them or they would be able to have like a good chat about what it might be like and- you know that’s sometimes like the nicest bits of the job but it’s not always possible to do, and inevitably will be one of the things that will go off the diary first if things are getting busy... Like we have got an OT actually that’s started recently who started, who has started- like people have been referring to him to do kind of like activity checklists with people and yeah, signposting to stuff in the community and working with some peer groups, so yeah I wonder if it is- it’s just about maybe having more capacity as a team, so we’re not just care coordinators, you know, we’ve got more kind of OT capacity or more like support worker capacity, instead of me just dropping into like a conversation, oh by the way there’s like a sports group on a Thursday*

> *More staff and also more people with that expertise, you know staff with those expertise. I think it would be helpful if we had more Care Coordinators just so that we have more time to think about that and support people on that, but it would also be helpful to have people that have got a specific expertise and connections in the community and connections with organisations*

> *It probably needs to be bigger, based on the need, where we can you know really drill down and ensure that we are properly exploring any interest that people have at the beginning when they are fresh when they are more enthusiastic, they are more open to working with services, if they have made that decision to do that I think when you are presenting them with interventions you know, you have got to strike at the beginning and really convince them we can help you*

One Care Coordinator talked about the possibility of SLaM doing more to directly provide employment opportunities to service users:

> *I guess like the placements that I was talking about like (vocational service) seem to have set up, could there be more of that done through SLaM? And I know that SLaM send apprenticeships through and things like that which some of them I think… we're meant to think about service users for them. So there is stuff that comes along*

There seemed to be limited awareness of the range of support that exists within SLaM but outside of specific community teams, such as those that exist through the Vocational Services team.

Local vocational resources

There were mixed perspectives on whether local resources are plentiful or fairly limited; for some Care Coordinators, views were informed by relative (lack of) provision as compared to other services in which they had worked. Some Care Coordinators felt they lacked detailed knowledge of local vocational support services:

> *Maybe it would be helpful to have something that was more like central bit of information, because I feel like it is all quite like bitty across community organisations and different staff that we have here at SLaM and I don't really know how, but being able to pull that all together rather than just the individual Care Coordinator thinking 'oh like who shall I refer them or what would be best for this person at this time'*

Some comments suggested that provision was somewhat uneven in terms of services available to meet the needs of clients at varying distances from work-readiness. There seemed to be a perception that while there are a couple of local services offering support for preparatory steps towards employability for people with lower skills, there is not much for people with higher skills/education who are ready to actually get a job, nor people falling somewhere in the middle ground:

> *At the moment I guess it feels quite all or nothing, like going back into employment is probably quite a big jump for some people. Like some people, they're employed or are full time and they are like it is fine, but for some people they feel that it would be too much and it doesn't really seem like there is always that many in betweens*

> *What I find is that in most of the client base, the clientele, the clients that I work with, they are severely affected by their mental health problems, and so it's kind of quite difficult. And then there's like two different ends of the spectrum as well. You've got some clients who are highly functioning, and they can function quite well, and they wouldn't mind finding a job. But at the same time, the services that we have available - that we can refer them to - doesn't really meet their needs... There are some clients who might have a degree or two. And when they are well, they are well, they are really - they are well. However, they seem to also look towards- look to us to support them for finding work. But at the same time, the services that we have available to us, our- we work with, for some reason they don't seem to cater to these type of clients... In most cases, what I find, there's not (many) jobs anyway. The services that we work with, it's about volunteering or attending activities*

> *It (employment/vocational activity) is part of the care plan and a part of the CPA process, but as I said, not much clients will really want to engage in that aspect of things. And then again, if they do, what is it that's out there for them to do? I think in most cases it's mostly training. Okay, you go for training, then what- what else?*

Again, these points about services that meet varying needs seem significant to explore in follow up with service users and providers.

One Care Coordinator queried the extent to which service users actually achieved employment outcomes from their engagement with these services:

> *I think they do (provide good service), with regards to support. But I don't see where I can say, okay, I can pinpoint a client, where I can say, yes, this person is working, have been referred to (name of vocational service) and they are working and they are earning, I haven't never- I haven't seen that*

Similarly, there was a view from another Care Coordinator that most participants who enter employment do so off their own initiative:

> *You know most of the people I know who end up getting a job have done it off their own back. So I actually feel very much in the dark about how effective our team is in translating that initial referral into a job or a course at the end*

This is consistent with the views expressed in conversations we have had with local employment support providers, most of whom said that only a small proportion of their referrals came directly from SLaM staff members.

Benefits and employers

All of the Care Coordinators we spoke to acknowledged the role played by both the benefits system and the labour market in influencing people's perceptions about the prospect of moving into employment and their actual ability to do so. Some spoke about service users being worried about losing their benefits if they moved into work:

> “ *I think for a lot of people, it's also the question about like benefits and how can they work and kind of negotiate still having enough money to pay the rent and live off, and I think some people are just really quite concerned about relapsing and I suppose a lot of what we do is kind of around stress management and feel that work would just be too much for them at this time*

> “ *People have definitely queried or worried about what it'll do or whether they will actually end up on less money*

> “ *What I find is that with some clients, they will explain to me that when they are working they wouldn't be able to- they wouldn't get as much money as they're getting. And so, they're getting over £1,000 per month, and from that money they don't have to pay any council tax, any rent, any so on and so forth, so, if they're able to get that amount of money per month, and not having to work, why would they look for work? Why would they want to work?*

There were also questions about how receptive employers were to taking on people with experience of mental health problems and whether the right support would be available:

> “ *I think stigma is still a big thing and- I think it's getting better but I think, yeah, faith that you are going to be supported by your employer*

> “ *Some of them might be, I would say, anxiety of what to expect, to go back. And some of them might be the stigma as well, I don't know, of maybe employees knowing- employers knowing why they left work or why they are not able to work anymore, and then trying to get back to work*

> *Employers that were open and maybe sensitive to people's challenges and more flexible with people who are trying to go back in or maybe like a longer phased return or you know just doing bits and bobs… because at the moment it feels quite all or nothing, like going back into employment is probably quite a big jump for some people*

> *I think having more employers willing to, I would say, give a chance to individuals who have suffered mental breakdown, have mental health illnesses*

> *I have often worked with young people with such talent, you know some highly educated, desperate to work, you know, I have got a couple of people on my caseload now who are so proud of their abilities and their strengths when they get a job, their problem is keeping that job. And what they always say is, "I just wish I had an employer where I could say upfront at the beginning look I have this vulnerability, and sometimes I am not going to be able to come in or I am going to crash, but I want to be upfront and transparent about that can we manage that together. Because I will give you my all, I will work so hard for you, but sometimes I am just not going to be able to do that". I have had that conversation with a number of people*

3) Influence of race and ethnicity

How race and ethnicity might impact experiences of mental health services

i) Issues relating to (lack of) mental health practitioner diversity and representativeness

Care Coordinators explained that the Early Onset Team is doing some work amongst staff to try and open up the conversation around issues of race, ethnicity, diversity. There is recognition that the team is made up of predominantly White women - this is not representative of their service users or community. Care Coordinators are reflecting on their own positionality - raising questions about whether it is appropriate for them to (and are they able to) open up conversations with service users about their experiences of race, both in relation to the mental health system and in relation to employment. There is recognition amongst the team that these are issues that need to be discussed and addressed, but uncertainty about how to go about this and what they should do:

> *If you're looking at the intersection of ethnicity and mental health and- I think it is there. And I think the team is trying to make quite tentative steps towards talking about that more and asking people about that in terms of like some of the trauma that has come through that. And I suppose trying to like then carve out that space in society to do, you know, the job that you might want to do or follow, you know, the vocation that you want to have. And I think we are trying to negotiate how much we go into that, especially I suppose we're, you know, a predominantly White female team as well, so I think we're maybe not having those conversations as much and therefore we can maybe hypothesise why people- how race and ethnicity could impact on people's work and vocation, but we don't- I don't think we are having those conversations enough*

> *As a team... we have got this group where we are trying to discuss issues around like racial inequalities and both its impact on staff, but- and staff from different ethnicities, but also our clients and how we can support clients in the best way. And we've had some really good discussions about how- that we generally shouldn't be kind of treating race and ethnicity as like the elephant in the room. As in that we should be addressing it more head on with clients, given the link- like given the demographic of our caseload, that we shouldn't be ignoring that that's a factor and that we should maybe be thinking also about how the fact that we aren't reflecting that demographic is also maybe an issue for people. And we're having some positive discussions about the fact that we should be doing stuff like that, but then that we don't really know the best or like safest way to do that. Yeah, so it is definitely something that people are trying- that I think that we feel that we're not doing well on, but don't know how to- don't necessarily feel we have the resources or the expertise, or the time, to be doing a much better job on it*

Care Coordinators felt it would be good to have more ethnic diversity within the team, to increase the breadth of cultural perspectives and to be more representative of service users and the wider community:

> *In terms of the service that we provide- I don't know and it is hard to say because also obviously different people of different ethnicity are going to bring different things and different cultural backgrounds, so I can't say that by having more of a diverse team, well we are going to definitely more knowledge or expertise on this that and the other, but I would have thought it might- it could bring some more... different perspectives, different cultural perspectives that would be important in terms of when we are sitting as a team and we are reflecting and we are thinking about things and thinking about different perspectives, it might be helpful to have that within the team*

> *I do think, you know, we can have consideration for the group that we present to service users, I think we do have a responsibility to try and be as a diverse as we can*

There were mixed views on whether SLaM is doing better or worse on diversity, as compared to prior experiences in other NHS Trusts:

> *I think the staff members in SLaM and patients… there is more (ethnic diversity) and the staff also there is more (ethnic diversity), and I feel like working in SLaM, patients and staff, there is a bit more better communication in staff than compared to when I worked for (other trust) whereas the ratio of the races is different and you can see a great divide in how people interact and things like that. So I get it. And not everybody is as culturally aware as they like to think that they are ... I will give an example: "Oh you are from Africa." No, I am not from Africa because it is a continent. You know stuff like that. And some people get really offended by that, service users and patients*

It was noted that a lack of ethnic diversity among mental health staff may (negatively) influence service user experiences and engagement:

> *I think probably a large proportion of my caseload - I'm just trying to think - are probably like a Black male. I think, well this is kind of an issue with the team, that we pretty much are all White women with a caseload that has a lot of Black men on it, within it. And I mean I- which I feel is an issue in itself, just- yeah, I don't think that we're like reflecting the people that we work with or that there is certain- I don't know, I don't know. Obviously everyone can learn, but there is certain- I don't know. It would just be helpful to have a more diverse team. And we should have a more diverse team generally… if people are confronted with a team where nobody looks like them - not their Doctor, not their Care Coordinator, nobody - I don't- I can't say how that feels, but I could guess that it might feel- I don't know, but not necessarily positive and might make people less likely to want to engage with the team even?*

Black Care Coordinators highlighted how their own ethnic backgrounds can be a benefit when engaging and supporting Black service users, as it helps with cultural awareness and sensitivity as well as increasing their understanding of service user perspectives and the kinds of things people might say or do in relation to their mental health. Mental health professionals from minority ethnic groups also played a role in educating their colleagues, sharing information and raising cultural awareness:

> *Obviously I am of an African background, so when certain situation arises and it is from culture I understand it just a- much better than my fellow Caucasian man or woman, do you understand. And it's just about getting the information to them for them to understand*

One Care Coordinator spoke about how there is good communication and an open, supportive, and constructively challenging ethos around raising overall levels of cultural awareness and sensitivity; they feel that Black service users' experiences are likely to be more positive because of this:

> *Our team's quite transparent and we are really supportive so when it comes to cultural stuff we explain… I just think our team is very open and transparent and things that others may shy from to bring up and discuss, where we are so diverse in the teams and we are comfortable and we are open and we want to know because we do not want to offend each other. Even if it might be uncomfortable like we say it… So in terms of how our patients are treated, I do not get that vibe from my team that anyone is treated differently because of their race. If anything we go an extra mile because of that to make sure that they feel included and listened to*

Whilst acknowledging that issues around race and ethnicity need to be talked about more, time constraints and competing priorities hinder the extent to which mental health professionals develop an understanding of, and culturally sensitive response to, different ways of expressing distress. The focus remains on immediate concerns of risk and risk management, with one Care Coordinator describing feeling that there isn't time to "be curious" about people's backgrounds, cultures or biographical experiences:

> *I think it is easier to maybe jump to conclusions of like- I think because yeah maybe we aren't having those conversations about like 'Have you grown up in an area where you have been the target of- on the receiving end of racism and how has that impacted on you and how- do you feel- has that contributed to your sense of self and well-being?' And I think we're maybe more likely to label people as aggressive or perhaps because, you know, cultural competence and not maybe understanding like that people express themselves differently and from different cultures and different backgrounds and different families. And I think that sometimes it's difficult to remain curious. And I know this is like a catch-all, you know, phrase but because we are, you know, so stretched and, you know, yeah, resources and you deal with crisis don't you, you're like, 'Well what's the presenting risk, who's at risk here, how do we address that'*

It was noted that some White mental health professionals can be defensive when issues of race and ethnicity are raised. There can sometimes be a degree of denial or defensiveness that an issue is connected to race or that it is always about race:

> *Sometimes they feel too- sometimes what I have come across is some people that are other (non-Black) race they become defensive and say, 'Oh it is not that, it is not that, you shouldn't always make it about race or something, it is mainly because of this...' But then when it boils down to it, it has been because of the race and cultural divide. So I think some people don't take things on and look at things like that initially. They just run to the defence mode straight away. Which doesn't really help*

The existence of unconscious bias was also recognised:

> *When a person got mental health issues, even though as staff we're not meant to be biased, of course there's still unconscious bias there. And in most cases when you're biased it's going to be negative*

ii) Issues around (lack of) trust

A major issue is lack of trust rooted in history and in the media; this can lead to perceptions of racism from mental health professionals, whether or not this is necessarily the case:

> *The people we work with, those from ethnic backgrounds, Black people especially, they do lack some sort of trust with, how do you call it, the White professionals, do you understand? They don't have the trust there so let's say a consultant who is seeing a Black patient, the consultant is White, the Black patient is really resistant in what the consultant is saying, saying 'you don't know me, you don't know where I come from, you don't know my background'... and sometimes the trauma of being sectioned and in hospital and that's going to intersect with your racial identity as well, going through the system and trusting people to support you through patients that are Black are comfortable with me being their Care Coordinator but are not comfortable with other White Care Coordinators. There's no reason, I'm not doing anything better than the other one is doing, but it's just solely based on mistrust*

Black service users may perceive that White mental health professionals don't understand them and where they are coming from. This can lead to resistance to engage in support or treatment. As noted above, where there is better diversity and representativeness, this can help with engaging and supporting Black service users:

> *Sometimes as a Black Care Coordinator- I won't say most of, I won't say the majority of my patients are Black, but we are in Lambeth so majority of (ethnic minority patients) are from ethnic Black backgrounds and I find some people are comfortable with me. Some of my patients that are Black are comfortable with me being their Care Coordinator - being their Care Coordinator - but are not comfortable with other White Care Coordinators. There's no reason, I'm not doing anything better than the other one is doing, but it's just solely based on mistrust*

The role of the police in mental health (particularly around sectioning), coupled with broader discrimination and mistreatment of Black people by police, may compound the mistrust of the mental health system:

> *We work closely with the police, don't we, and the trauma of being sectioned and in hospital and that's going to intersect with your racial identity as well, going through the system and trusting people to support you through that*

Potential impacts of race and ethnicity on how people are perceived and treated

There was recognition that different cultural and linguistic ways of expression may mean that things people do or say are misinterpreted. For example, assumptions may be made based on racial stereotypes, e.g. agitation interpreted as aggression; or talk about spirit(s) or prayer may be interpreted as delusional, rather than reflective of religious/spiritual beliefs that are held regardless of mental ill health, or a different use of terms or words:

> *I think in regards to assessment there's a cultural difference. There is definitely a cultural difference, because I have seen where a psychiatrist is assessing a client and they don't understand what the client is saying, but yet still you're assessing them, and you're making judgement based on what they're saying but you don't understand what they're saying. So there's a culture- I think there's one example where a client said to a- one of- a team member, 'my spirit don't take you', and it is written that the person is talking about spirits, and they are delusional, when in fact that's not what it means. It means that the person- there is something about you that they don't like. So there is a culture difference*

> *A patient of mine is, so she was talking more- a lot about religion, religion as in she believes in God, she believes in Jesus, and this consultant was just like is it a delusional talk. But me as a Black person I understand. Black people have religion, do you understand? I know where this person is coming from, it's not merely delusional... But if it's put down as delusion talk, because this person is religious, then it's wrong, do you get what I mean? They are not psychotic at that moment. They are well. They are just having their CPA and they think it's like- 'I think I am getting well because I am praying'. Give them that, it's what they believe in. Just give them. But when you consistently say 'Oh you think this is true, you think it's delusional, I think…' these are the things that make Black people really angry, do you understand? When it comes to putting them down, putting their religion, putting their beliefs down. So me, I say, I would approach it in a different way... But someone who does not understand and doesn't come from that background would not approach it. They would just take it as in all pertaining to mental health which is a bit uncomfortable to experience really*

It was suggested that mental health professionals who do not share a service user's cultural or ethnic background, sometimes struggle to understand the language or dialect of Black service users, and hence perceive them to be incoherent when they are not:

> *I had an example as well when I was involved in a (Mental Health Act assessment), like a first rec (first recommendation for a section), and I do understand what the person is saying because the person is from my cultural background, and in the assessment it was written that the person was incoherent when in fact they weren't, they were clear, 'cos I understand what they were saying, only because the person is from a different culture so they didn't understand what the person is saying. And so I had to approach them, I said no, she wasn't incoherent, she was clear. She was unwell, she was becoming unwell, but she wasn't incoherent*

> *I think the topic of cultural differences in assessment, I think you should always, and even though you have persons from my community who speaks patois, and it's a broken- and you know it's considered English, there's things that a person might say that you don't understand from a cultural context and so I do believe that you should always have someone to be able to interpret what the person is saying, so you can have a full understanding before you can make a decision, an informed decision*

There was recognition of statistical differences and inequalities around diagnoses, sectioning, medication and restraint. However, Care Coordinators in this study offered diverse views on the extent to which this kind of differential treatment is witnessed within their own services. Some said they had no actual observations of Black service users being treated differently or in a discriminatory way within their service, whilst others seemed to imply they do see differences in terms of interpretations of aggression and quick recourse to sedation:

> “
> *I have come across a lot of racial stereotypes and the word ‘aggressive’ it gets thrown around a lot with Black males, in law, in everything, ‘Oh they were very aggressive’ and that’s the comment all the time. Oh yes, ‘oh that was really aggressive’ and sometimes the way they speak, sometimes the way you come across to them as well, you know, so yes so that is there with that one I see it a lot, even in-patients I see that a lot... he’s being aggressive and unnecessarily injecting them and, yeah, it happens, it is there and it’s obvious - its not a hidden thing*

> “
> *I don’t have any specific examples of observing other professionals sort of doing things in a way that I do not think is helpful or is discriminatory. I cannot say that*

There was a perception that these issues arise through a combination of individual mental health professionals’ attitudes or lack of awareness and more overarching institutional racism:

> “
> *I think it’s both really; it’s both. Because I think individually people don’t understand, do you understand? And they don’t know, they are not aware, but they are not being racist, do you understand, they are just not aware of it, they don’t know the background quite well, they don’t {deep/dip} down to know this person, okay someone from an African background would think this way, someone from the Caribbean background would think this way, someone from the Asian background would believe in this kind of thing and that’s their belief. Even a well person, someone we say they are well and living well in the community and doesn’t have any mental health issues believes in the same thing, do you understand? They would express the same concern, express the same {thing to you} so yes, so why would you think because this person has mental health this is pertaining to their mental health? Do you understand what I am saying? So I think individuals need to learn more and institutions as well need to*

Potential impacts of race and ethnicity on employment

There was recognition of the intersecting and compounding effects of mental health stigma, and racial inequalities and stereotypes, in both the mental health system and within employment and the labour market. These combined factors could have an impact in terms of employment disadvantage in the labour market, and in terms of lowering self- esteem and confidence around attempting vocational activity or employment:

> *I think to use an example of somebody who I'm supporting, who is a young Black man... living in South London who has had two quite public psychotic episodes. And I think the impact on his self-esteem and the knowledge of kind of the I suppose, stereotypes and inequality towards Black men, you know, in psychiatry, and kind of how he is viewed socially... I think it is the main thing at the moment, kind of impeding this idea of recovery. You know, if we are to look at recovery as having what I said earlier about kind of, you know, sense of purpose and enjoyment and social connection, and maybe doing the things that he wants to do, I think he feels quite paralysed by his experience and also what that experience means in the context of being a Black man. So that is some of the conversations that I've had with him and he's been having in psychology. I think that's kind of like my most sort of like kind of direct experience of it*

> *The stats are out there. A person from- especially from the Black community, especially young Black men, are most likely to be unemployed. So the stats are out there. And can imagine that is compounded with having mental health issues. What would that look like? And also the stigma of having mental health issues as well*

> *That would be tougher. That would be an added burden. Because being Black without even any history of mental health and getting employment is hard. You are always told work twice as hard or five times as hard as your White counterpart, in school, you are being told they will choose the White person before you anyway even though your qualifications are higher. This is something that we are being told since we are young so, and even being well and going for a job, you are like oh they will give it to the White person, so having mental health now that's an added, how do you call it, glass wall as well, do you understand? Just- Yes, it's tough, it is tough, it's really, really tough*

There was recognition of the complex and multiple range of socioeconomic obstacles that may form part of Black service users’ experiences, e.g. low education attainment, gang involvement, prison/criminal justice involvement, mental health stigma, racial prejudice.

Often there are a multitude of challenges that need to be supported before a person is ready to enter employment. Race and ethnicity may be one factor (and an intersecting factor), but is not the only factor. For some service users, the complexity and multitude of barriers, the distance to travel before ready for work, can feel insurmountable - hence people may feel it’s not even worth trying:

> “ *My thoughts would be, you know, it is hard enough if you have had a mental health episode or you are under services it is hard enough to just you know on so many levels and layers of trying to get your life together there is so much working against you and so it is additional stigma, is it not that they are having to encounter, it is hard enough trying to get back into employment and explaining why you have got a chequered or you know a stop start employment history. I have definitely had conversations with my Black service users about that and the difficulties with that and trying to explain you know past background in order to sort of be accepted and taken on in a new role. But yeah, I mean obviously all of the research would tell you particularly young Black men that we work with, there is just so much for them to overcome to get to the point they are even able to make job applications and get the interview and get taken on, you know, it is just such, it just feels like there are so many hurdles they have got to get over. I mean for example in my service we also have a number of people in terms of their backgrounds they have been involved in gang culture, they have dropped out of school, you know there is a trajectory there that often you see really similar themes in there and then to get to a point where even though they have said look I have had a mental health episode, I have had all of these things happen before where I am not skilled up, I did not finish my education, but how do you get to that point where to try and get into a job. There is just a massive gap, there is a gap of space, there is a gap where they have to account for themselves and I think it is just feels for some of them insurmountable and that is why they think well what is the point in trying. So yeah, I think it is just factoring in that there are certain experiences that some of our Black and ethnic service users have that we need to try to get a handle on, and maybe work that bit harder because we need to figure out how to help them to account for things that have happened and why they are at a point of age 24 where they have might have been in hospital, they might have been in prison, they have not finished school, you know, and how we can fill that gap because they are wanting to, to get them to a place where they want to be and get a job. But often it feels it is just such, you know so many traumatic experiences, I have so many service users as I say who have had traumatic childhoods and real difficulties with gang culture and there is a lot of trauma there as well, additional trauma. So it is just difficult to get to that stage where they can try and go legit and get a job*

Potential impacts of race and ethnicity on employment support

Care Coordinators recognised how preconceptions and stereotypes might feed into an assumption that Black service users are not interested in vocational or employment activity. Another potential scenario was that if services users are seen as difficult to work with e.g. because of perceived aggression, or because of accusations of racism, mental health professionals might distance themselves, offering less support or trying to hand them on. It is important to note here that these scenarios had not actually been seen in practice by the Care Coordinators - but were suppositions of potential scenarios.

> *I haven't experienced that, I would say… There's nothing to put my finger on to say yes, that would be- but I do believe… that could be the case, do you understand? Yes, or they could be down as difficult to work with and this avoidance thing can come through…saying oh I will avoid this patient, they are really difficult to work with, they are very challenging, they talk about me being racist all the time and I really- they will try to kind of avoid to work with them or signpost, or give them to someone else*

It is important to note that Care Coordinators reported no actual observations or experiences of Black service users being less likely to be offered employment support. There was no direct perception of any differential treatment in terms of encouragement towards employment or vocational activity:

> *I don't really have the evidence or haven't noticed anything specifically about whether we are less likely to then offer that to certain groups as part of their recovery and therefore whether they're missing out on something. I don't know*

There was recognition that the relationship between mental health and (un)employment is bi-directional; and that each of these can be affected by race/racialised experiences. The complexity of interwoven socioeconomic issues might contribute to poorer mental health outcomes and poorer employment outcomes specifically for Black people:

> *I was on some training recently and we were kind of having a think about this and about how, you know, all of the statistics about how, you know, there is more restraint with Black service users and maybe they are being offered less- fewer other opportunities and I think it is an issue and it's hard to know where the issue is coming from, whether it's- well it is probably a whole layer of things, we were talking about the four I's of oppression and it is probably all of them*

07

Discussion

The small sample of interviews means that any findings can only be treated as tentative. However, there are nonetheless important issues and themes raised in the interviews that offer an insight into the ability of Care Coordinators within SLaM's community teams in Lambeth to support service users around employment and other vocational activity. The views and experiences of the Care Coordinators we spoke to also point to broader issues related to SLaM policies and processes, and levels of prioritisation and funding for employment & other vocational objectives, that warrant further discussion and exploration.

Below we have summarised the key issues and themes from our findings, with a focus on those that have most directly informed the conclusions and recommendations we have set out in the final section of this service evaluation.

Prioritisation of employment/vocational activity at service and organisational level

From our interviews, the overall picture was that employment and other vocational activity are seen as important objectives in theory. However, in practice they are not given much resource and are not strongly promoted through mechanisms such as KPIs and the CPA process. This contributes towards these objectives becoming a lower priority on a day-to- day basis. Interviewees suggested that if higher status and priority were given to employment and other vocational activity at an organisational level (in terms of messaging, resourcing and strategy), and by individual managers and senior leaders, then Care Coordinators might have more ability and incentive to promote and support these objectives with service users.

Care Coordinators’ desire and capacity to focus on employment

Employment and other vocational activity is seen by most Care Coordinators as important and valuable to service users. Care Coordinators will raise this with service users in conversation and will signpost to specialist workers where available. These specialist workers are valued, both for their more in-depth expertise and their greater capacity to focus on employment where Care Coordinators’ time is constrained by other priorities and KPIs. Some Care Coordinators would like to get more directly involved with support, such as accompanying service users to appointments or initial sessions at providers, but time constraints limit capacity to do so. The size of caseloads was a key barrier to Care Coordinators focusing more time on these objectives, as they reported having insufficient time to do so, as they were pulled towards dealing with crises rather than focusing on longer-term goals. It seemed that the professional background of Care Coordinators (e.g. Social Workers compared to nurses) may play a part in shaping how much they prioritise and feel able to support these objectives, but that is a tentative conclusion from a small sample.

Nature of employment/vocational support available

There was a mixed response from Care Coordinators in terms of their awareness of what support was available around employment and other vocational activity, both within and outside of SLaM, and their perceptions of the quality of this support. Those working in teams with specialist staff dedicated to these objectives valued this support, but felt it was under-resourced. There seemed to be little awareness of other services available within SLaM such as Lambeth Vocational Services, but there was support for the idea of more in-house services and in-house employment opportunities. Most Care Coordinators knew of some community services offering support but there was recognition that there is probably a lot of services they are not aware of. Some Care Coordinators raised concerns about a lack of appropriate support for people who had good qualifications or previous work experience.

Barriers to accessing employment/vocational activity

A range of barriers were noted, including those stemming from service user circumstances and work-readiness, service constraints, employer attitudes and the welfare system. It was suggested that the extent to which service users felt open to the idea of employment or other vocational activity depended, in large part, on both the direct impacts of their mental health problems (and medication) but also how ‘unwell’ they saw themselves as being and how this had been shaped by their experience of services. In general, there was recognition of the complexity of barriers people are facing. It was suggested that racial discrimination can be a direct factor in limiting the ability of someone with mental health problems to move into employment, or an intersecting factor with other barriers people face.

How race and ethnicity impact on service user experiences

Overall, there was recognition that race and ethnicity might play a role around aspects of assessment, medication and clinical treatment within mental health services - this may be linked to cultural misunderstandings and (mis)interpretations of behaviour. However, given the scale of the disproportionate rates of access and the poorer outcomes experienced by Black people in particular, and minority ethnic groups in general, it was perhaps surprising that Care Coordinators were relatively tentative in recognising systemic racism. In terms of differential treatment around employment support, there seemed to be less perception that this occurred, though Care Coordinators speculated on how it might arise, as a product of the complex and intersecting challenges that arise around race, employment and mental health.

08

Conclusion and Recommendations

As with the discussion above, our conclusions and recommendations are offered with the caveat that we are drawing on a small sample of evidence. However, we believe our findings and the potential action they point towards are consistent with the wider evidence and consensus about the need for a stronger focus on social outcomes, such as employment and other vocational activity, within mental health services. We also believe that the evidence we have gathered offers valuable insight into why services may be struggling to focus on and fulfil these objectives, and as such what might be done to improve the quality of support available and the likelihood of service users engaging with this support.

We suggest that SLaM works in collaboration with staff and service users to further investigate the issues we have raised and develop potential solutions. This work could form part of existing projects such as the Living Well Collaborative. However, based on our findings we have suggested some broad recommendations below to help guide and inform this process. We believe these suggestions could help improve the accessibility and quality of support around employment and other vocational activity for SLaM service users.[17]

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[17] Although we hope to see increased focus on employment and vocational activity within SLaM's community mental health services, we also want to flag the importance of how these issues are raised and approached with service users. Many people feel pressured to move towards work by the benefits system and the wider political/media narrative around benefits. This pressure is often counter-productive, making people feel more unwell and less able to take steps towards employment or other vocational activity. As such, implementation of these recommendations would need to be mindful of this context in order to ensure that service users feel supported and encouraged rather than pressured.

1) Employment and other vocational activity should be given higher status and priority at an organisational and strategic level

The Care Coordinators we spoke to did not feel that employment and other vocational activity were presented as high profile or high status objectives within SLaM as an organisation. They suggested that this was then reflected in the relatively low priority these objectives hold within individual teams and in their own day-to-day work. Giving greater visibility and emphasis to these objectives across the Trust could improve the ability of staff to deliver relevant support and increase the likelihood of them doing so.

- Review the extent to which these objectives are meaningfully prioritised in the Trust's strategy and how this is supported through policies, processes and measurement
- Clear and regular communication across the Trust that emphasises the importance of these objectives, highlights available services and support, and demonstrates the potential impact through case studies of service user outcomes

2) Team objectives and processes should incentivise staff to ensure service users are supported and encouraged around employment and other vocational activity

Care Coordinators understood their services to be primarily focused on risk management, medication, the stabilisation of symptoms, psychological intervention and physical health checks - all of which were underpinned and driven by associated KPIs. Overall, Care Coordinators suggested that employment and other vocational outcomes are not given particularly high priority at a service level.

As well as encouraging a greater focus on these objectives, better measurement and reporting of relevant activity would help health services build the case for greater investment based on the contribution they can make to people finding and maintaining employment.

- Engagement with support around employment and other vocational activity across a team's caseload should be recorded and reported as a KPI
- Tools such as Dialogue may help to better incorporate and reflect these kind of objectives and activities in formal KPI reporting
- Up-to-date employment and benefit statuses should be recorded on service users' notes and any changes in status should be reported on a regular basis
- The CPA process, or any processes that replace CPAs in the future, should more explicitly focus on employment and other vocational activity

3) Greater attention should be given to the impact of high caseloads on the ability of staff to focus on longer-term objectives such as employment

All the Care Coordinators we spoke to told us that the size of their caseloads is a key limitation on their ability to focus on longer-term, more social objectives such as employment and other vocational activity. Large caseloads mean that Care Coordinator time may be thinly spread between service users and the more likely it is that their time will be taken up dealing with a crisis. We recognise that large caseloads are likely to be caused by resource pressures.

- Investigate and monitor how the size of caseloads impacts on the ability of staff to focus on longer-term social objectives such as employment
- Use this evidence to make the case to commissioners, NHS England and central government that high caseloads are restricting capacity to deliver these objectives

4) In-house support and opportunities with SLaM around employment and other vocational activities should be better resourced and utilised

Care Coordinators really valued having dedicated support around employment and other vocational activity within their teams. However, they reported that this support was under- resourced and overstretched. As well as offering better in-house support, and better utilising existing support, there is potential to offer more direct opportunities for employment and vocational activity within the Trust.

- Review the take-up and outcomes of existing in-house support services to investigate how well they are being utilised, and to develop a business case for greater investment in these services and resources
- Efforts should be made to ensure all staff in community teams are aware of support and resources available within SLaM and rates of referral should be monitored
- Care Coordinators and other staff should be offered support and advice on how to directly support service users towards employment and other vocational activity
- Consider how SLaM can offer more direct opportunities to service users through contracting of services, such as cleaning

5) There should be more collaboration and integration between SLaM and community organisations offering support around employment and other vocational activities

We know from other work that Black Thrive Lambeth is conducting with community organisations in Lambeth that there is a wealth of support available around employment and other vocational activity. However, the Care Coordinators we spoke to were often only aware of one or two relevant services and acknowledged that they often didn’t know how to find out more about what other relevant services might be available for referral or signposting.

- Ensure staff have easy access to a comprehensive and up-to-date directory of available support from community services and are encouraged to utilise this
- Collaborate with the ‘No Wrong Door’ project to better support service users to access appropriate support from community organisations quickly and easily
- Consider the challenges faced by service users with previous experience or qualifications, whose needs and aspirations might not be adequately catered for by services more focused on basic skills and entry-level jobs

6) Access to support around employment and other vocational activity should be considered as part of efforts to address racial and ethnic inequalities across SLaM

Black people in particular, and minority ethnic groups in general, are not only overrepresented in secondary mental health services but also face disadvantages in the labour market - in combination these are huge barriers for people to overcome. Given this context, particular consideration should be given to how well SLaM engages and supports people from minority ethnic groups around employment and vocational activity.

- Explore with staff whether there is a risk that service users from minority ethnic groups are treated with different perceptions and expectations around objectives such as employment and what could be done to correct for any bias
- Ensure Care Coordinators and other staff are aware of culturally appropriate community services they can refer people onto for support with these objectives
- Consider how support around employment and other vocational activity for minority ethnic groups could be incorporated into relevant policies and strategies, such as the Patient and Carer Race Equality Framework (PCREF)

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Appendices

Appendix One - Participant information sheet

Thank you for considering participating in this service evaluation which will take place between June and August 2021. This information sheet outlines the purpose of the service evaluation and provides a description of your involvement and rights as a participant, if you agree to take part.

1) What is the research about?

This service evaluation is exploring how employment and other vocational activity is accessed within community mental health teams in Lambeth, and how well equipped care coordinators feel to support service users with these objectives.

2) Do I have to take part?

It is up to you to decide whether or not to take part - you are under no obligation to do so. If you do decide to take part we will ask you to verbally give consent for the interview at the meeting.

3) What will my involvement be?

You will be asked to take part in an interview about your experience as a care coordinator, with a focus on supporting service users with employment and other vocational activity (such as training or volunteering). It should take approximately 45 minutes, and certainly no more than one hour.

4) How do I withdraw from the study?

You can withdraw from the service evaluation at any point until publication of the data, without having to give a reason. If any questions during the interview make you feel uncomfortable, you do not have to answer them. Withdrawing from the service evaluation will have no effect on you. If you withdraw from the service evaluation, we will not retain the information you have given thus far, unless you are happy for me to do so.

5) What will my information be used for?

We will use the collected information for a research project about support with employment and vocational activity in community mental health teams, which we hope will ultimately help to improve outcomes for service users.

6) Will my taking part and my data be kept confidential? Will it be anonymised?

The records from this service evaluation will be kept as confidential as possible, following GDPR guidelines. Only the research team will have access to the files and any audio tapes. Your data will be anonymised – your name will not be used in any reports or publications resulting from the study. All digital files, transcripts and summaries will be given codes and stored separately from any names or other direct identification of participants. Any hard copies of research information will be kept in locked files at all times.

Limits to confidentiality: confidentiality will be maintained as far as it is possible, unless you tell us something which implies that you or someone you mention might be in significant danger of harm and unable to act for themselves; in this case, we may have to inform the relevant agencies of this, but we would discuss this with you first.

7) Who has reviewed this study?

This study has been approved by Lambeth Governance at South London and Maudsley NHS Trust.

8) Data Protection Privacy Notice

This service evaluation is based at South London and Maudsley NHS Trust. We will keep any information you share with us securely, and it will only be accessible to the project team. If you share your contact details with us they will only be kept for as long as you participate in the project in order to update you on the project findings. We will not share your contact information with any external organisations. To find out more, including your rights and who to contact if you have a concern, please see SLaM's core privacy notice at: https://slam.nhs.uk/personal-information-gdpr

9) What if I have a question or complaint?

If you have any questions regarding this service evaluation please contact the lead evaluator, Tom Pollard (tpollard@slam.nhs.uk)

If you have any concerns or complaints regarding the conduct of this research, please contact informationgovernance@slam.nhs.uk

10) Providing informed consent

If you are happy to take part in this study, we will ask you to verbally agree to the questions below:

a. I have read and understood the study information, or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.

b. I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and that I can withdraw from the study at any time up until the publication of the results, without having to give a reason.

c. I agree to the interview being audio recorded

d. I understand that the information I provide will be used for research publication and that the information will be anonymised.

e. I agree that my (anonymised) information can be quoted in research outputs.

f. I understand that any personal information that can identify me will be kept confidential and not shared with anyone beyond the study team.

g. I give permission for the (anonymised) information I provide to be deposited in a data archive so that it may be used for future research.

Appendix Two - Interview topic guide

1) How long have you worked as a care coordinator and what attracted you to the role?

a. How long have you been in SLaM and this particular team?

b. What's your professional background?

2) How would you describe the role of a care coordinator?

a. What are the main objectives and responsibilities of a care coordinator?

b. Which of these objectives and responsibilities have the greatest priority?

c. [If not already sufficiently covered] Can you tell me more about the type of support you provide to service users?

d. How does your professional background shape how you approach the role?

3) Have the priorities of the role changed since you've been a care coordinator?

a. How? [Prompt: Case loads, administration, other aspects]

b. What KPIs are used to monitor how you are supporting service users?

c. How much do these KPIs shape how you prioritise different aspects of the role?

d. Ideally, how do you think care coordinators should be splitting their time between different aspects of their role?

e. Is there anything that prevents you spending more time on these aspects of your role?

4) What do you see as the key elements of 'recovery' for the people you support?

a. To what extent do you feel able to support people towards what you see as recovery?

b. [If not already mentioned] Is employment something you encourage service users you support to work towards?

c. Do you explore people's previous experiences of work (if they have any) and how this has shaped their perspective and aspirations?

5) What do you think are the main barriers that stand in the way of more service users on your team's caseload moving into employment?

a. **[If not already mentioned] prompt on specific issues**
    i) The impact of their condition/symptoms
    ii) The demands that having a job would place on them
    iii) The attitudes/receptiveness of employers
    iv) Having the right support to move into employment
    v) Anxieties about the impact on their benefits/financial situation
    vi) Opportunities for employment and general levels of unemployment

6) Are any of the service users you support actively trying to move into employment?

a. Do you feel equipped to support someone towards this objective?
b. Do you feel like you know where to refer someone for further support
c. What do you think of the support/resources available within SLaM to support service users with employment?
d. What do you think of the support available from voluntary/community groups in Lambeth to support service users with employment?
e. Are there any other issues that might impact on your ability to support someone with employment or direct them to good support?

7) Do you find the CPA process to be helpful for you and/or service users?

a. What do you think the benefits of the process are?
b. What doesn't work well about the process?
c. Does employment/vocational activity often come up as a point of discussion with service users, carers and other staff as part of this process?
d. In your experience, when that conversation happens does it tend to be initiated by you or by service users/carers?
e. Do you usually write something about employment as part of someone's care plan or CPA review?
f. Do you usually record people's employment and benefits status?

8) To what extent do you think employment/vocational/social inclusion activity as objectives for service users are seen as a priority within your team?

a. Are you actively encouraged to focus on this objective by your line manager/service manager?
b. Is it promoted as an objective in SLaM-wide communications?
c. Do you feel it is sufficiently prioritised/promoted as an objective within your team and within the trust as a whole?
d. What changes within your service might help improve employment outcomes?
e. What changes outside of your service might help improve employment outcomes for the service users your service supports?

9) What issues (if any) related to race and ethnicity come up in your work?

a. In your experience, how might someone's race and ethnicity impact on their experience of mental health services?

b. How might it impact on how they are perceived by mental health professionals?

c. How might someone's race and ethnicity impact on the type of support they are offered and the type of objectives they are encouraged to work towards?

d. Do you think someone's race and ethnicity might impact on how likely they are to move into work if they have had mental health problems?

10) Is there anything else you would like to say about the topics we have discussed today?

Appendix Three - Coding index

1) ROLE DESCRIPTION, OBJECTIVES AND PRIORITIES

a. Background

- How long has worked as a care coordinator and what attracted them to the role
- How long in SLaM and in this particular team?
- Professional background
- How their professional background shapes how they approach the role

b. Describing the role of Care Coordinator

- How they would describe the role of a care coordinator
- Main objectives and responsibilities
- Type of support they provide to service users

c. Priorities of the role

- Which of their objectives and responsibilities have the greatest priority?
- Have priorities of the role changed since they became a care coordinator? How?
- Ideally, how do they think CCs should be splitting their time between different aspects of their role?
- Anything that prevents them spending more time on these aspects of role?

d. Recovery

- What do you see as the key elements of 'recovery' for the people you support?
- To what extent do you feel able to support people towards what you see as recovery?

e. KPIs

- What KPIs are used to monitor how they support service users?
- How much do these KPIs shape how they prioritise different aspects of the role?

f. Other

2) SUPPORTING AND ENCOURAGING EMPLOYMENT

a. Prioritising employment

- To what extent are employment/vocational/social inclusion activity as objectives for service users seen as a priority within their team?
- Are they actively encouraged to focus on this objective by your line manager/service manager?
- Is employment promoted as an objective in SLaM-wide communications?
- Do they feel employment is sufficiently prioritised/promoted as an objective within your team and within the trust as a whole?

b. Supporting and encouraging service users towards employment

- Are any service users they support actively trying to move into employment?
- Is employment something you encourage service users you support to work towards?
- Do you explore people's previous experiences of work (if they have any) and how this has shaped their perspective and aspirations?

c. Perceptions of own ability to support

- Do they feel equipped to support someone towards this objective?
- Do they feel like they know where to refer someone for further support?

d. Perceptions of other sources of support

- What do you think of the support/resources available within SLaM to support service users with employment?
- What do you think of the support available from voluntary/community groups in Lambeth to support service users with employment?

e. Perceived barriers to more service users on their team's caseload moving into employment

- Spontaneous responses, responses to prompts, perceptions of any other issues that might impact on ability to support someone with employment or direct them to good support

f. Improving employment outcomes for service users

- Changes within service that might help improve employment outcomes
- Changes outside of service that might help improve employment outcomes

g. **Other**

3) CARE PLANNING PROCESS

a. Do they find the CPA process to be helpful for them and/or service users?

  - Perceived benefits of the process
  - Perceptions of what doesn't work well about the process

b. Does employment/vocational activity often come up as a point of discussion with service users, carers and other staff as part of CPA process?

  - When that conversation happens does it tend to be initiated by CC or by service users/carers?

c. Do they usually write something about employment as part of someone's care plan or CPA review?

d. Do they usually record people's employment and benefits status?

e. Other

4) RACE AND ETHNICITY

a. What issues (if any) related to race and ethnicity come up in their work?

b. Experience/perceptions of how someone's race and ethnicity might impact on their experience of mental health services

c. Perceptions of how race and ethnicity impact on how service users are perceived by mental health professionals

d. Perceptions of how service user race and ethnicity might impact on the type of support they are offered and the type of objectives they are encouraged to work towards

e. Perceptions of how service user race and ethnicity might impact on how likely they are to move into work if they have had mental health problems

f. Other

Lambeth Black Thrive

Centre for Society and Mental Health

Supported by Impact on Urban Health

King's College London

NHS
South London and Maudsley
NHS Foundation Trust