Appendix 2: October 2006

NOTTINGHAMSHIRE HEALTHCARE NHS TRUST
Nottingham City and South Nottinghamshire

SOCIAL INCLUSION AND WELLBEING:
VOCATIONAL SERVICES STRATEGY

CONTENTS

1.0 Introduction

An employment strategy for Nottinghamshire Healthcare Trust in Nottingham City and South Nottinghamshire is appropriate and timely. It is appropriate because most service users see employment as a key recovery goal and a means to social inclusion. Yet their chances of getting a job are worse now than 40 years ago. In 1966, people who had been in Mapperley Hospital with a diagnosis of schizophrenia were followed up 12 months after leaving hospital. At the time, researchers were disappointed that 'only' 40% were working[1]. Today, that figure would be nearer 10%. Despite all the advances of psychiatric treatment, community care, new medication and psychological therapies, employment outcomes have got worse, not better. This same 'three hospitals' study was among the first to demonstrate that the single most protective factor in preventing the negative effects of institutionalism was time spend engaged in purposeful activity. There is no reason to think that levels of discrimination have changed, and the unemployment rate has only increased by 1% over this period. It is therefore appropriate for services to plan how they can respond to the need for constructive occupation expressed by service users. An employment strategy is timely because general rates of employment are high and the health and social care policy climate is favourable for people with mental health problems returning to work, as will be seen below.

[1] Brown, G., Bone, M., Dalison, B. and Wing, J. (1966) Schizoprenia and Social Care: A comparative follow up study of 339 schizophrenic patients. London: OUP. Table 4.1 page 74. Cooper (1961) is cited in the same book as reporting a 63% rate of being self supporting after 2-6 years for 237 'first admitted schizophrenic men'.

2.0 Policy Review

Following on from the emphasis on social inclusion in Standard One of the *National Service Framework for Mental Health* (Department of Health, 1999), the *Social Exclusion Unit's Mental Health and Social Exclusion Report* (ODPM, 2004) highlighted the issues for people with severe mental health problems. Meanwhile, the inter-relationship between employment, mental health and social inclusion has been acknowledged in general health and employment policy documents: the *Framework for Vocational Rehabilitation* (Department for Work and Pensions, 2005); and the joint strategy of the Department of Health, Department for Work and Pensions and the Health and Safety Executive, *Health, Work and Well-being*. Driven by this 'welfare to work' agenda, legislative and policy reforms have tackled several of the barriers facing people with mental health problems who wish to work, notably those posed by discrimination, marginalisation and the benefits trap.

Discrimination - The **Disability Discrimination Act (DDA) 1995** makes it illegal for employers to discriminate on grounds of disability. They are required to make 'reasonable adjustments' to their work practice and environment to accommodate employees with disabilities. These adjustments may simply involve a more flexible approach to a job. However, it is difficult to legislate for positive attitudes towards disabled people when they are not present in significant numbers in the workplace.

Marginalisation - The Disability Discrimination Act (DDA) 2005 seeks to overcome disabled people's marginalisation in the workplace. Implemented in December 2006, it imposes 'a duty on all public bodies to promote equality of opportunity for disabled people. This means that they must take account of the needs of disabled people as an integral part of their policies, practices and procedures, and not as something separate or as a tag-on. They will have to have due regard to the need to: eliminate unlawful discrimination and disability-related harassment; promote equality of opportunity and positive attitudes to disabled people; and encourage disabled people to participate in public life' (DDA 2005, p1).

Benefits Trap - The **National Minimum Wage**, introduced in 2001, makes it less likely than before that some people receive more in welfare benefits than they can earn[2]. There are also incentives for disabled people to enter employment, including Permitted Earnings, the 52 week linking rule which protects benefit entitlements, and the Access to Work fund which can meet the costs of some adaptations and adjustments.

[2] In 2006 a single person aged 25 is entitled to £57.45 Income Support. The adult minimum wage is £5.35 per hour. Anyone working 11 hours at the minimum wage or fewer hours at a higher wage would therefore be better off than on benefits. However, there are still complex calculations to be made for people who get Housing Benefit, Council Tax Benefit and free prescriptions.

The most radical change to the benefits system is heralded by the **Welfare Reform Bill** published in July 2006 (<http://www.dwp.gov.uk/aboutus/welfarereform>accessed August 17, 2006). This will see Incapacity Benefit replaced by a new Employment and Support Allowance. This will place a greater obligation on those deemed fit to pursue employment or 'work related activity' to accept appropriate guidance and condition management for any relevant health problem or risk loss of benefits. Although there will be exemption from these obligations for those deemed unfit there is a danger that it will be at the expense of re-exclusion from mainstream vocational guidance and other support. People currently on Incapacity Benefit will retain it but their level of disability will be reviewed more often and if they are capable, just like new claimants, they will be expected to demonstrate that they are making efforts to find a job (Refer to "The Executive Summary of the Green Paper: Empowering people to work").

In addition, the Bill identifies a timetable for the rollout of **Pathways to Work** nationally. In Nottinghamshire, this will occur in October 2007, and the main contractor will come from the private or voluntary sector. Although the final form is undecided and pressure continues from various lobbying groups the default assumption is that: "New customers taking part in Pathways to Work attend an initial work focused interview with a trained personal adviser. Most will then go on to attend another 5 work focused interviews with the same adviser at monthly intervals. During the interviews the adviser will help the customer to identify future life and work goals and any barriers to achieving them, and will support the customer in overcoming those barriers. An action plan will be agreed detailing the activities the customer has identified to undertake, and this will be reviewed at each meeting."[3]

The anticipation of a review may make people anxious at the possibility of a reduction in their benefits entitlement, and this may have an adverse effect on their mental health unless key workers are fully informed and able to allay their fears. People with ongoing mental health problems will face a dilemma. They may be judged through their new **Personal Capacity Assessment** procedure to be eligible for exemption from further review of their capacity to work. In that case they will also forfeit the support into work available from Jobcentre Plus, leaving health and social care services to meet their vocational aspirations.

There are additional opportunities within the reformed system but these will require strengthening of partnerships between employment and mental health sectors locally if they are to be realised. One of these is afforded by Nottingham's recent successful bid within the Cities Strategy. This gives a local consortium some limited funding and flexibilities in order to produce an innovative locally appropriate strategy to reduce unemployment. A local

[3] JobCentre Plus website <http://www.jobcentreplus.gov.uk/JCP/Customers/Programmesandservices/Pathways_to_Work/index.html> accessed 2006-08-07.

consortium has been established led by **One Nottingham (the City LSP)** and a final plan will be agreed with DWP later this year. Mental health services are represented on the consortium.

Box 1 Local Area Agreements

Local Area Agreements (LAAs) are negotiated by local authorities on behalf of their local strategic partnerships (LSP) and their Government Office (GO) on behalf of central government. They provide an opportunity to consider, negotiate, agree and deliver local and national outcomes. The agreements are based upon mature discussions between local and central government leading to more relevant outcomes for local areas with devolved responsibility to respond and deliver. LAAs aim to align or rationalise funding resources, reduce bureaucracy, and enhance efficiency. LAAs are signed-off by Government after months of detailed preparation by local authorities and their partners and in depth discussion and negotiation with their GO. <http://www.idea-knowledge.gov.uk/idk/core/page.do?pageId=4456650> accessed August 7, 2006

Implications for local public sector services

Local area agreements

Local Area Agreements (LAAs) are defined in Box 1. Employment of people with mental health problems figures as an objective of both Nottingham city and Nottinghamshire LAAs. The city LAA has 'improving adult mental health' as one of its outcomes, to be measured by the percentage of people on Enhanced Care Programme Approach (CPA) being supported in open employment, mainstream education or volunteering[4]. The Nottinghamshire LAA endorses the same outcome, and sets a target of 60% of people known to secondary services being supported in open employment, mainstream education or volunteering by 2009[4]. Therefore this vocational services strategy has considerable convergence with the LAAs for both Nottingham and Nottinghamshire. A joint City and County scoping group accountable to the overall partnership bodies for the LAA has been established to produce an action plan for implementation. Initial steps are largely identical to those proposed within this strategy and it makes sense for a single group to take on both tasks. The LAA group has agreed that its work should be fully integrated into the implementation process for this strategy.

Implications for health and social care services

The policy climate favourable for people with mental health problems wishing to work, indeed, as shown above, there are increasing pressures on them to consider this option. Most service users rely on the state benefits system for their income and housing needs. Mental health and social care services have a responsibility to prepare their users to cope with the new benefits environment, while responding to their demands for social inclusion through adequate support into work or other valued occupational activity.

Under the *DDA 2005* Public Sector Duty on Disability employers like Nottinghamshire Healthcare NHS are required Trust to produce an equality strategy demonstrating how they

[4] <http://www.gnpartnership.org.uk/local-area-agreements> accessed 2006-08-07

are actively promoting equality for disabled people (staff and service users). This strategy constitutes evidence for such a plan.

The **Ten High Impact Changes for Mental Health Services** published in June, 2006[5] include the following recommendations. As will be seen below, this strategy corresponds directly to at least two of them with respect to vocational services.

- Increase the reliability of interventions by designing care around what is known to work and that service users and carers inform and influence.
- Apply a systematic approach to enable the recovery of people with long term conditions.

Box 2 SEU report objectives

Health and social care services will tackle social exclusion through:
- modernised vocational services which reflect evidence-based practice and provide a choice of services to meet diverse needs;
- access to an employment adviser and social support for everyone with severe mental health problems;
- redesigning mental health day services to promote social inclusion;
- improved access to vocational and social support in primary care;
- strengthened training on social inclusion for health and social care professionals;

Office of the Deputy Prime Minister (2004) Social Exclusion Unit Report: Mental Health and Social Exclusion, page 8.

The SEU report cited in Box 2 states that secondary care services provided by mental health trusts have an important role to promote social and vocational opportunities for people with severe and enduring mental health problems (para 20), that inpatient services staff should identify if people are in employment or education at the time of admission, maintain contact with families, and help resolve any financial issues (para 23), and that Standard Five of the Mental Health NSF set a target that by March 2002, for all written care plans for people on enhanced CPA to show plans to secure suitable employment or other occupational activity (para 25).

Supporting Social Inclusion has been identified as one of the Ten Essential Shared Capabilities of all staff in mental health services. It is important that the service improvement and practice development initiatives with mental health teams which are put in place for this strategy form part of an integrated development process which also encompass the other capabilities especially in the areas of Values, Recovery and Person Centred Planning[6].

[5] <www.nimhe.csip.org.uk/10highimpactchanges> accessed 16 August, 2006)
[6] Ten Essential Shared Capabilities <http://kc.nimhe.org.uk/upload/78582-DoH-10%20Essentials.pdf accessed 17 Aug 06.

Implications for employment services

The Social Exclusion Unit Report also places additional responsibilities upon the employment sector to:

- improve access to employment programmes through rollout of the Pathways to Work programme nationally; testing the impact of longer periods of support; strengthening partnerships with mental health services; improving training for Incapacity Benefit personal advisers; clarifying guidance and improving access to New Deal programmes through better incentives; tailoring support to individual need and greater consultation with users,
- ease the transition from benefits to work through improving information about DLA eligibility; making the IB linking rules more flexible and evaluation of the Permitted Work rules, and
- promote enterprise and self-employment by providing better support.

SEU Report Local Implementation

A Steering Group has produced recommendations for implementation as part of an overall wellbeing strategy for Nottingham and Notts. These have been agreed by all local health and social care commissioning bodies. They endorses the DH Commissioning Guidance in supporting the production of a Vocational Services/Employment Strategy for Mental Health and the establishment of a forum for implementation.

NHS as exemplar employer

In 2002, the Department of Health published guidance on employment of people with mental health problems within the NHS[7] . Even before this guidance, Nottinghamshire Healthcare Trust has been proactive in employing service users, and their contribution to its services is valued highly. Policy No PE/32: User Employment Policy and Operational Framework, was implemented from Jan 2004[8]. The overarching message of the DH guidance on employment of people with mental health problems within the NHS is that 'it is extremely unjust, a waste of human potential, a great cost to society, and potentially unlawful to exclude anyone from employment simply because that person has experienced or experiences mental health problems.' Specifically, applied to the NHS as employer, the guidelines shown in Box 3 are offered. They reflect compliance with the DDA from an employer's perspective.

[7] Department of Health (2001) *Mental Health and Employment in the NHS.* Executive Summary.

[8] The Trust's commitment to user employment is evident in the April 2006 document 'Mental Health & Learning Disabilities Employment Strategy. Trust Wide Application', by Mike Hudson-Scott and Charlotte Whyman.

Box 3 Executive Summary *Mental Health and Employment in the NHS*

Selection should be based on the best person for the job. Appropriate procedures should therefore be implemented so that persons with disabilities are not placed at a substantial disadvantage compared to non-disabled persons in the in the arrangements made for determining who should be offered employment in the NHS;

Every assessment for a post is specific to that situation;

All NHS staff should have a pre employment health assessment;

NHS employers should ensure their policies and procedures comply with the Disability Discrimination Act 1995;

No applicant should be refused employment on health grounds unless expert occupational medical advice has been sought;

No person should be refused employment, or have their employment terminated on mental health grounds without the NHS employer first having made any adjustments that it would be reasonable to make in relation to that person in accordance with any duty placed upon them by the DDA;

The "2 year rule" (suggested by the Clothier Report) which some occupational health professionals have used when carrying out pre employment health assessments to bar service users from working in health care professions is no longer to be used in the NHS;

All NHS staff need help to develop an awareness of their own mental health, when to seek help and from whom;

The NHS needs to develop a culture where staff can be open about their mental health status, are treated fairly and are encouraged to seek help when it is needed;

NHS managers should be aware that the DDA makes it unlawful to refuse employment or to terminate the employment of a disabled person for a reason relating to that person's disability without justification. The reason for that decision must be one that cannot be removed by any reasonable adjustment made by or on behalf of the employer.

3.0 Evidence review

There is a substantial amount of evidence which indicates how secondary services can help people with mental health problems gain employment. A review of the literature on occupational outcomes in mental health commissioned by NIMHE[9] found unanimous agreement among experts with the evidence-based statements given in Box 4.

Box 4: F**actors which promote service user employment**

Service users with severe mental health problems are more likely to get work if:

- they have worked before
- they are not experiencing the negative symptoms of psychosis
- they have good social skills
- they are not impaired cognitively
- they have positive attitudes towards work
- they are placed as soon as possible in a job of their choice
- they receive ongoing support, and
- their vocational service is integrated with their mental health care.

There was also agreement among the experts that The Individual Placement and Support (IPS) model of supported employment has strong evidence in its favour. The IPS model draws on practices which have been shown to be effective (Drake et al., 1999)[10] and a scale for measuring adherence to the IPS model has been developed and implemented (Bond et al., 1997, 2000)[11]. The service-level criteria of fidelity to this model are shown in Appendix 1. It is described by the SEU report as shown in Box 5. A Cochrane review[12] summarised the evidence in favour of IPS in 2001, and it has continued to amass positive results, including a

[9] NIMHE (2003) Expert briefing: Employment for people with mental health problems. Department of Health. Available at: http://www.sesami.org.uk/employment_report.pdf accessed 31 July, 2006.

[10] Drake, R. E., Becker, D. R., Clark, R. E. and Mueser, K. T. (1999a) Research on the individual placement and support model of supported employment, *Psychiatric Quarterly*, 70, 4, 289-301.

[11] Bond, G.R., Becker, D.R., Drake, R.E. & Vogler, K.M. (1997). A fidelity scale for the individual placement and support model of supported employment. *Rehabilitation Counselling Bulletin,* 40 265-284. Bond, G. R., Evans, L., Salyers, M., Williams, J. and Kim, H.-W. (2000) Measurement of fidelity in psychiatric rehabilitation, *Mental Health services research,* **2,** 2**,** 75-87.

[12] Crowther R, Marshall M, Bond G, Huxley P. Vocational rehabilitation for people with severe mental illness. *The Cochrane Database of Systematic Reviews* 2001, Issue 2 http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003080/frame.html [accessed 29/07/05]

growing body of evidence from countries other than the US (Latimer et al., 2006[13]; Rinaldi et al., 2004[14]).

Box 5 Individual Placement and Support Model of Supported Employment

The Individual Placement and Support (IPS) approach is evidence-based and built on six key principles:

- finding employment in integrated/mainstream settings ('real work');
- immediate job search, with minimal pre-vocational training;
- support from vocational workers based in clinical teams, with employment an integral part of the overall care plan;
- job search driven by client preferences and choice;
- continual assessment of individuals' needs, with support adjusted as necessary and assistance in career progression; and
- access to ongoing support on a time-unlimited basis once in work, with appropriate workplace interventions to enable job retention.

(ODPM, 2004, p57)

IPS forms the core of the vocational services recommended for people with severe mental health problems published by the Department of Health in 2006: *Vocational services for people with severe mental health problems: Commissioning guidance*[15]. This document is effectively the benchmark against which mental health services providing employment support will be judged. It brings together the policy and evidence reviewed above into explicit structures and targets for services. At its core (Table 1, p17-19) it specifies the key features of five aspects of provision, together with their key linkages to other aspects of employment support, the recommended level of provision, the number of people served and indicators by which their performance may be evaluated. These five features include; a local multi-agency employment forum, NHS as an exemplar employer of people with mental health problems, clinical vocational leads in provider teams, employment specialists in teams, and social enterprises or firms. This commissioning guidance is therefore very influential in developing the strategy proposed here.

Job retention

The evidence base in relation job retention is not extensive. Primary care interventions for job retention in relation to common mental disorders have been reviewed recently by the British

[13] Latimer, E., Lecomte, T., Becker, D., Drake, R., Duclos, I., Piat, M., Lahaie, N., St. Pierre, M-S, Therrien, C. and Xie,H. (2006) Generalisablity of the individual placement and support model of supported employment: results of a Canadian randomised controlled trial. *British Journal of Psychiatry* 189, 65-73.

[14] Rinaldi,M., McNeil, K., Firn, M., Koletsi, M., Perkins, R. and Singh, S. (2004) What are the benefits of evidence-based supported employment for patients with first-episode psychosis? Psychiatric Bulletin 28, 281-284.

[15] CSIP for Department of Work and Pensions and Department of Health, February, 2006. Available at: http://www.info4local.gov.uk/searchreport.asp?frompage=rss&id=28302 accessed October 16 2006.

Occupational Health Research Foundation[16]. Short courses of cognitive behaviour therapy emerge as the most promising intervention for common mental disorders among people in employment whose usual provider would be primary care.

Secondary care services for job retention are not well developed, possibly due to the low employment rate among clients. The South Essex Employment Strategy tells us that the Avon and Wiltshire Partnership Mental Health Trust found that 80% of service users who were employed on admission to hospital lost their job as a result of their admission (Butterworth, 2001[17]). AWPMHT implemented a job retention service and demonstrated that a case management model is effective in ensuring that people do not lose their job, or are able to find a new job more appropriate to their circumstances (Thomas et al., 2004[18]). Previous research and the AWPMHT evaluation indicate that effective case management comprises the features shown in Box 6[19].

Box 6 **Elements of an effective job retention service for people in employment**

1. Confidential vocational counselling addressing employment issues, job satisfaction and preferences, and disclosure issues
2. Confidential mental health counselling addressing mental health issues, symptom management in the workplace, perspectives on illness, psychological detachment from work, self esteem and self identity
3. A primary allegiance to the client where the employer is unwilling to engage with the service
4. A more neutral stance when the employer is willing to engage
5. Advocacy for the client in the workplace
6. Specialist advice on the DDA, legal issues and relevant financial incentives/benefits
7. Information, advice and training for employers on dealing with mental health issues
8. Training for employers on healthy workplaces for all employees
9. Facilitation of communication between employee and employer regarding time off work, return to work plans, modified work programmes and adjustments
10. Facilitation of natural supports within the workplace
11. Referral processes that promote early intervention and are easily accessed by employers and employees
12. Keeping all parties informed, including mental health workers & GPs
13. Ongoing support to manage any problems in the workplace that arise as time goes on
14. Information, advice and training on employment issues for mental health workers and GPs.

[16] BOHRF (no date) Systematic review of workplace interventions for people with common mental health problems. A summary for mental health professionals. http://www.bohrf.org.uk/downloads/cmh_hp.pdf> accessed 2006-08-10

[17] Butterworth R. (2001) Job retention – developing a service. *Mental Health Review*, 6, 4, 17-20.

[18] Thomas T., Secker J. & Grove B. (2004) Working all together. *Mental Health Today*, June, pp.30-33.

[19] Thanks to Professor Jennifer Secker for permission to quote the South Essex Employment Strategy.

4.0 Scope, aims and objectives

Scope

The scope of this strategy is Nottingham city and conurbation: Broxtowe including Hucknall, Rushcliffe and Gedling. It applies to users of Adult Mental Health Services provided by Nottinghamshire Healthcare Trust.

Aim

The overall aim of this strategy is to promote recovery, social inclusion and wellbeing by:

(i) enabling service users of working age to gain access to employment of their choice,

(ii) raising staff expectations of users' employment,

(iii) maintaining exemplary practice as a Trust employing service users,

(iv) recognising and promoting the role of education and voluntary work in equipping people to work, and

(v) meeting occupational needs of people who are not ready to work in ways which demonstrate their contribution to an inclusive society.

Objectives

Trust-level objectives

1. To build partnership working with service users, carers, local authorities, Jobcentre Plus, social enterprises, voluntary organisations and employer organisations to promote positive vocational outcomes for people with mental health problems.
2. To foster social enterprises to meet the needs of people who do not aspire to open employment through partnership with the voluntary and private sectors, in line with national guidance.
3. To regard paid employment as the norm for adults of working age, and to offer at all levels (inpatient, community and day care) services which do not prevent people from working.
4. To treat paid employment as a key indicator of recovery from mental health problems.
5. To monitor effective care planning in relation to employment.
6. To monitor rates of employment and work-related activities for people who are treated by clinical teams.
7. To be exemplary in the recruitment, retention and promotion of people with mental health problems as employees within the Trust.

8. To establish a programme to ensure that staff are continually aware of the employment strategy, effective employment interventions and local resources.

Service level objectives

9. To develop designated clinical staff as vocational leads for employment in each community team and clinical leadership across the service.
10. To give every clinical team access to a nominated employment specialist, who can undertake job appraisal, job searching and placement in permanent employment, with ongoing support, following the IPS model.
11. To develop the skills of support workers to supplement the work of employment specialists.
12. To give every clinical team access to a nominated education specialist whose responsibility it is to liaise with further and higher education establishments, NIACE, LSC as necessary, supporting clients into education and afterwards as required.
13. To give every clinical team access to a nominated volunteering specialist, who can assess clients' potential to volunteer and match this with local opportunities, providing support after placement.
14. To locate responsibility for co-ordinating the work of the specialists and the clinical leads with a senior operational manager with overall responsibility for social inclusion (through employment, education, volunteering, sports, leisure and the arts).

Practitioner level objectives

15. To identify employment or education status on first assessment and review this throughout the therapeutic intervention.
16. To ensure that access to expert benefits advice is available to people who need it.
17. To advocate with employers or colleges where this might preserve a client's current employment or education
18. To promote employability by building users' self confidence with respect to work (e.g. through psychological therapy, work trials or training).
19. To offer access to an employment advisor for everyone with severe mental health problems who wishes to consult one.
20. To use the Ten Essential Shared Capabilities for Mental Health Practice to promote employment outcomes, particularly by *challenging inequality*, *promoting recovery* and *making a difference.*

5.0 Needs and resources

5.1 Estimating the scale of need

There are no reliable statistics on whether service users of the Trust are in employment, and if so, whether this is full or part-time, paid or voluntary. National statistics indicate that the employment rate for people with mental illness is 18.4% (Smith & Twomey, 2002[20]). The SEU report, which takes account of people who are retired, carers, homemakers, in voluntary work or in education estimates that only 24% of people with severe mental health problems are adequately occupied.

A caseload audit in June 2006 of the community teams in the city of Nottingham and the south of the county identified 2597 clients, 90% of whom are on the caseloads of the six Community Mental Health Teams, the remainder being seen by one Early Intervention in Psychosis and three Assertive Outreach teams. Of all clients, 1094 (42%) are on an enhanced CPA, indicating that they have severe and enduring mental health problems.

What type of needs?

Needs for vocational services are not uniform. People's attitudes to their own employability are shaped by their contacts with mental health services as well as their own experiences of acceptance or rejection by employers and colleagues. There are three overlapping client groups with broadly distinctive employment support needs:

People with mild to moderate mental health problems (anxiety and /or depression, PD) who are finding it difficult to continue working or to get a job because of these problems. They are likely to be on standard CPA or none. The main responsibility for this group of service users lies in Primary Care. They need treatment which takes into account their employment issues, helping them to retain employment if they are already in work. Jobcentre Plus services, including Pathways to Work, can sometimes satisfy their requirements, such as practical assistance with benefits, vocational profiling and job seeking. Those people in this group who are long-term unemployed may require more support from secondary services, including psychological interventions to build their confidence. Employment specialists may for example link with primary care staff concerning work-related issues, or advocate with employers on behalf of this group of service users,

Young people (roughly 18-25)[21], with first episode mental illness, drug use problems or problematic alcohol use. A high proportion of these clients will be seen in the EIP and AO

[20] Smith, A. and Twomey, B. (2002) Labour market experiences of people with disabilities. Labour Market Trends. August. 415-426.

[21] The EIP accepts people with first episode illness aged up to 35.

teams. These people will have limited work experience and career plans. Their education is jeopardised by their mental health problems, with knock on effects for employment. It is important to create links with the world of work while promoting education, vocational skills development and career planning. Some young people require help to acquire basic skills in literacy and numeracy.

People with severe and enduring mental health problems who require co-ordinated clinical care. They may have spent substantial amounts of time as inpatients in psychiatric hospital, with the consequent stigma, so their 'distance from the labour market' is greater than the other two groups'. They are likely to be on medication, and their confidence about their ability to work will be low. For some, basic skills will be poor, and they may never have acquired work-related skills. These people are the main clients of IPS services, because their needs can best be met through this structured approach.

Responding comprehensively to vocational needs

The proposed vocational services strategy will meet the needs of individuals in each of these categories and be flexible enough to support any who fall outside the categories as well. It will offer individually planned and socially inclusive strategies by integrating clinical management with vocational services. These will include opportunities:

- to explore their talents and develop their abilities,
- to build confidence about their potential to work,
- to identify aspirations and career ambitions,
- to engage with the world of work in a safe environment,
- to attain the satisfaction and status of paid employment,
- to develop a career path which leads to economic independence, and
- to promote self-management and choice within these opportunities on offer.

Therefore the vocational services proposed here include education and volunteering as fundamental parts of the overall strategy, together with employment support. However, the proposed approach is not programmatic or 'stepped'; a person may enter the provision at any point which suits them. The vocational strategy sees paid employment as the priority for adults of working age who wish to work. For these people, intermediary activities such as education or training should be directed towards a work-related outcome.

5.2 Existing resources

The Trust currently employs several staff whose main function is to promote vocational outcomes. This includes 3.5 Bridge Builders who act as employment specialists and accept referrals from mental health services. Two of these are funded by City local authority. An Education Co-ordinator (0.8 WTE) and a full time Volunteers Co-ordinator are also employed by the Trust.

The community teams and inpatient wards already have an allocation of occupational therapists, in most cases this amounts to 0.5 of a post. In addition, there is a complement of community occupational therapists (OTs), including technical instructors (TIs), plus OT and TI staff at SPAN and Broad Street. Some of these posts have been designated as Support, Time and Recovery workers.

In these settings, there are also nurses and healthcare assistants. A number of administrative and clerical (A&C) staff support all three groups of clinical staff. Table 1 shows the current actual WTE staff in these three settings. Leaving aside the nursing, healthcare assistants and administrative staff, there are 11.62 OTs and 13.7 TIs currently deployed in these three services.

Table 1: Existing staffing totals

Summary (WTE actual)	Span	Broad St	Community OTs	Total
Total OT WTE	1.72	4.44	5.46	11.62
Total TI	6.16	3.7	3.84	13.7
Total Nurse	0.99	3.72	0	4.71
Total HA	0	1.6	0	1.6
Total A&C	0.78	0.53	2.43	3.74

6.0 Proposed structures staffing and functions

Employment strategy group - In keeping with the national guidance, a trust-wide multi-agency employment strategy group (forum) will be established. This will take responsibility for implementing this strategy and the Local Area Agreement with respect to employment. It will build partnership working between user groups, health and social care commissioners and Jobcentre Plus. It will link closely to social enterprises, voluntary organisations and employer organisations who are concerned with vocational outcomes for people with mental health problems. It will oversee the Trust's policies with respect to user employment and the NHS as an exemplar employer. It will monitor practice developments in line with the emerging evidence base and foster research. It will establish links with the north of the county with a view to developing a county-wide strategy. It might be chaired by a Non-Executive Director, and report to the AMHS Partnership Board.

Vocational services manager – This person will have responsibility for convening the employment strategy group, managing the vocational service and promoting training and best practice to take account of changing needs. The person in this role is responsible for ensuring that the vocational services meet the occupational needs of all service users, including those for whom employment is not a realistic option. He or she will need to be pro-active in working with voluntary sector providers and others to create opportunities for socially inclusive options, such as social enterprises, arts and leisure activities and personal development.

Clinical vocational lead - Subject to the outcome of the community review[22], in keeping with the DH guidance on commissioning vocational services for people with mental health problems, this strategy proposes that there be a clinical vocational lead in each community team. In most cases this will be the occupational therapist. An outline of the role based on the DH guidance for commissioners is attached at Appendix 2. It should be seen as function which might be performed by any clinical professional, although occupational therapists have particularly relevant skills. Briefly, the clinical vocational leads will be responsible for championing employment and education issues within the team. They will liaise closely with the team's employment specialist, and be responsible for ensuring that vocational issues form part of assessment, care planning and review within the team.

Employment specialist - In addition to the clinical vocational lead, each team will have an allocated employment specialist (one team per specialist). The DH guidance places this post in Band 5. A job description for this post is given in the "Vocational services for people with severe mental health problems: Commissioning guidance" document, page 28ff.

Employment specialists will actively engage with team members to generate referrals for vocational input. They may work with care co-ordinators, users and employers to promote job

[22] The imminent reorganisation of community teams is likely to result in a smaller number of teams.

retention, where necessary. They will carry a caseload of no more than 25 active clients at any one time and follow the evidence based principles of IPS (see Appendix 1). Employment specialists will also be responsible for tackling systemic obstacles to work for their clients: educating employers about the advantages of inclusive employment practices, helping carers to understand the role of work in recovery from mental health problems, and fighting stigma in the community.

The employment specialists will form a separate team for management and related purposes. The existing group of 3.5 Employment Bridge Builders, will be augmented so that each community team has one WTE employment specialist. Within the Social Inclusion service, employment specialists will be able to call on the resources of STR workers, who may support users in relation to: benefits issues, Jobcentre Plus visits, CV preparation, visiting workplaces, going to interviews etc.

Volunteering specialist – The person responsible for enabling service users to undertake voluntary work will form part of the social inclusion and wellbeing service. This person will liaise with education and employment specialists and external organisations which use volunteers' services, and will support and monitor service users in voluntary placements.

Education specialist – The person responsible for service user education will form part of the social inclusion and wellbeing service, and will receive referrals from Employment Specialists as well as from elsewhere. This person will have significant expertise in the educational opportunities available for adults, and they will liaise with colleges, universities and other educational bodies. The education specialist will support and monitor service users in education and may for example be responsible for ensuring that all service users acquire basic skills to NVQ Level 2.

7.0 Monitoring outputs and measuring outcomes

National indicators

The SEU report has a majority of employment and vocational indicators among those which it puts forward to monitor its action plan implementation. Those national indicators most relevant to this strategy are shown in Table 2 below. While the strategy supports the outcomes shown in Table 2, they can only be measured at a national level.

Local indicators

1. At local level, we propose, firstly, that the Trust monitor the four local indicators recommended by the SEU differentiating between clients on enhanced and standard CPA in each community team. A data collection tool for this purpose is given in Appendix 3. These measures should be obtained as soon as possible as a baseline for implementation of this strategy:

- Number of people on the CPA being supported in open employment
- Number of people on the CPA being supported in mainstream education
- Number of people on the CPA working as a volunteer, and
- Number of people with mental health problems employed by mental health trusts, local authorities and other public sector bodies[23].

2. The LAA indicators for the city correspond to those listed above, and the county includes these as well. The county LAA also sets a target of 60% of people known to secondary services being supported in open employment, mainstream education or volunteering by 2009[4]. The Employment Strategy Group should establish a system to ensure that attainment of this target can be monitored.

3. Fidelity of services to the IPS model should be monitored by the Employment Strategy Group.

4. It is desirable to monitor how many people are being assessed for vocational needs on admission to hospital, at first assessment, and at CPA reviews. Clinical vocational leads should work with Information Services to set up a monitoring system for this process.

[23] It is most feasible to count new recruits to the Trust who declare their user status.

Table 2: Taken from ODPM (2004) Annex C p 120-121.

Indicator	Data source	Outcome
Employment		
People with mental health problems in paid work	Labour Force Survey (LFS)	Year on year increase in numbers and proportion
Income and benefits		
Income growth for people with mental health problems with the lowest income	Psychiatric Morbidity Survey (PMS)	Decrease in proportion of pwmhp in lowest 3 deciles
Number of people with mhp on Incapacity Benefit	IB administrative data	Decrease in numbers and proportion
Education		
Number of people with mhp with no qualifications	LFS/PMS	Decrease in numbers and proportion
Number achieving NVQ level 2 or equivalent	LFS/PMS	Increase in numbers and proportion

Appendix a

The Supported Employment Fidelity Scale

1. **How many cases does each employment specialist (full-time equivalent) have on his/her caseload?**

   1 = 81 or more
   2 = 61 - 80
   3 = 41 – 60
   4 = 26 – 40
   5 = 25 or fewer

2. **Do any of the employment specialists provide other mental health services besides vocational? If so, how much of their time do they spend on providing non-vocational services?**

   1 = 80% or more
   2 = about 60 %
   3 = about 40%
   4 = about 20%
   5 = Provide only vocational services

3. **Do different employment specialists provide different aspects of the vocational service? If so, what different aspects of the vocational process do they provide?**

   1 = Only refer to other services/programmes

   2 = Maintain caseload but refer to other programmes for vocational service

   3 = Provide one aspect of vocational service e.g. assessment, job placement, job preparation, follow up support

   4 = Provide two or more aspects but not the whole service

   5 = Carry out all aspects of the vocational service

4. **What level of contact do employment specialists have with mental health services?**

   1 = Part of a separate programme, no regular direct contact with mental health staff, or only telephone or one face to face contact per month

   2 = Attend mental health team meetings once a month

   3 = Have several contacts each month and attend one team meeting per month

   4 = Attached to one or more mental health teams with shared decision making, attend weekly team meetings

   5 = Attached to one or more mental health teams with shared decision making, attend one or more team meetings each week and have at least three client-related care coordinator contacts per week

5. **Do the employment specialists work together as a vocational unit?**

   1 = Not part of a vocational unit

   2 = Have the same supervisor but don't meet as a group

   3 = Have the same supervisor and discuss cases but don't provide services for each other's clients

   4 = Form a vocational unit. Discuss cases and provide services for each other's clients

   5 = Form a unit with group supervision at least weekly. Provide services for each other's clients and back up and support for each other

6. **What are the eligibility criteria for the service?**

   1 = Clients screened out on the basis of job readiness, substance use, history of violence, low level of functioning etc, usually by care coordinator

   2 = Some eligibility criteria. Screened by vocational staff who make referrals to other programmes

   3 = Some eligibility criteria. Screened by vocational staff of the programme that will provide the vocational service

   4 = All adult clients with severe and enduring mental health problems are eligible. Participation is voluntary

   5 = All clients are encouraged to participate. Referrals are solicited from several sources (self, family, self-help groups etc.)

7. **How and where are clients assessed?**

   1 = Prior to job placement using standardised tests /desk-based assessments

   2 = Prior to job placement using work experiences available at the programme site e.g. for testing computing skills

   3 = In a sheltered setting where clients carry out work for pay

   4 = Most of the assessment is based on brief job experiences in the community that are set up with employers

   5 = Vocational assessment is ongoing in community jobs rather than through a battery of tests. Minimal testing may be used but not as a prerequisite to job searching. Aimed at problem solving using environmental assessments and consideration f reasonable adjustments

8. **After how long with the service would a client start usually looking for a job?**

   1 = After a year or more
   2 = After 9 to 12 months
   3 = After 6 to 9 months
   4 = After 1 to 6 months
   5 = Within 1 month

9. **Who decides which jobs should be targeted for clients and how do they decide?**

   1 = Employment specialist decides unilaterally, usually driven by nature of job market

   2 = About 25% of decisions reflect client preferences, strengths, needs etc, rather than the job market

   3 = About 50% of decisions reflect client preferences, strengths, needs etc, rather than the job market

   4 = About 75% of decisions reflect client preferences, strengths, needs etc, rather than the job market

   5 = Most decisions are based on job choices that reflect client preferences, strengths, needs etc, rather than the job market

10. **What percentage of the employment specialists' clients are in the same job setting or the same type of job?**

    1 = Most
    2 = 75%
    3 = 50%
    4 = 25%
    5 = 10% or less

11. **What percentage of the jobs that the employment specialists suggest to clients are permanent, competitive jobs?**

    1 = Very few
    2 = 25%
    3 = 50%
    4 = 75%
    5 = Virtually all

12. **Do employment specialists help clients to find another job when one ends?**

    1 = Not usually
    2 = 25% of the time
    3 = 50% of the time
    4 = 75% of the time
    5 = Almost always

13. **What proportion of clients in work would usually be receiving follow up support and for how long?**

    1 = No follow-up support provided

    2 = Time limited support provided to less than half

    3 = Time limited support provided to most

    4 = Ongoing support provided to less than half

    5 = Ongoing support provided for most

14. **Where do the employment specialists spend most of their time? What percentage of their time would be spent in the community?**

    1 = 10% or less spent in natural community settings

    2 = 11-39% spent in natural community settings

    3 = 40-59% spent in natural community settings

    4 = 60-69% spent in natural community settings

    5 = 70% or more spent in natural community settings

15. **Do the employment specialists provide any outreach if a client does not engage or drops out of services?**

    1 = Do not provide outreach

    2 = Make one attempt to contact

    3 = Make one or two attempts to contact as part of initial engagement and within a month when clients stop attending

    4 = Make attempts to contact as part of initial engagement and at least every two months for a time limited period when clients stop attending

    5 = Provide outreach as part of initial engagement and at least monthly on a time unlimited basis when clients stop attending

Reference
Bond, G., Vogler, K., Resnick, S. et al. (2001) Dimensions of supported employment: Factor structure of the IPS fidelity scale. Journal of Mental Health, Volume 10, Number 4, 383-398.

Appendix b

Role of Clinical Vocational Lead in Community Mental Health Teams
Taken from Vocational services for people with severe mental health problems: Commissioning guidance Table 1: Commissioning framework for vocational services.

Key features

- A mental health professional with an interest in vocational rehabilitation.
- Takes a clinical perspective on vocational rehabilitation.
- Offers advice and guidance on vocational matters to other team members.
- Provides brief interventions that help clients to achieve their vocational preferences and choices.
- Works closely with the employment specialist.
- Has good working relationships with local providers (including education, volunteering, etc).

Key linkages

To employment specialists

Performance indicator

Reduction of people on community team caseloads not involved in meaningful occupation.

Appendix C DRAFT DATA COLLECTION FORM

VOCATIONAL OUTCOMES MONITORING

Background information	Form completed by:		
	Team name:		
	Date:		
Contact details	Name:		
	Telephone:		
At date given above:	Number on enhanced CPA	Number on standard CPA	Number not on CPA
Total team caseload	A1	B1	C1
For at least 2 hours per week:			
Number in open employment	A2	B2	C2
Number employed in the Trust, social services or LEA	A3	B3	C3
Number working as a volunteer	A4	B4	C4
Number in mainstream education	A5	B5	C5

Note: Nobody should fall into more than one of the categories A1 to C5. If more than one condition applies to a person, count them only in the higher level. For example, if a person is a volunteer and at college, they should be included in level 4 but not level 5. If in addition they worked part time in the Trust, they would be counted at level 3, not 4 or 5.

This form should be returned to: