National Development Team for inclusion

YORKSHIRE AND HUMBER IMPROVEMENT PARTNERSHIP

A GUIDE TO PRODUCING A COMMISSIONING STRATEGY FOR MENTAL HEALTH EMPLOYMENT

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This document has been written as part of the YHIP funded NDTi work in Yorkshire & Humberside to support the writing and review of local employment plans. We recommend that it is used in partnership with government policy as it is published and updated.

Agencies based outside the region who would like to know more about the project, employment planning or the NDTi please visit our website www.ndti.org.uk

Document prepared by Peter Bates, NDTi, August 2010.

Scope of this document

Policy and guidance that relates to the task of improving employment opportunities for people with mental health issues falls into two categories:

- General materials that affect people with mental health issues and those who are treated less favourably in the labour market for other reasons – learning disability, ethnicity, physical and sensory impairment, age and so on. This includes items such as:
    - *Improving health and work: changing lives. The Government response to the Black Review.*
    - DWP (2008) *No one written off: reforming welfare to reward responsibility*.
- Materials targeted specifically at people with mental health issues – see below.

This document focuses upon the messages emanating from the second group of materials, although some of the action points that arise may repeat items originating in the first group.

The field is fast-moving and the new UK government is eager to make changes and so this document will need to be updated from time to time.

The goal of this policy stream is open, waged employment, paid at National Minimum Wage (NMW) levels or higher and working for 16 or more hours per week. This may include social enterprises or self employment, as long as people are employees and receive at least the NMW. Other arrangements, such as permitted work, volunteering and education are included as part of the spectrum of supports that should lead to this goal, but are not entirely satisfactory outcomes in themselves, although they may, of course, satisfy other policy obligations such as Recovery, and work just right for a minority of people.

After a brief listing of government and other guidance, the elements that should be included in a commissioning strategy are listed, along with the sources of the directive.

Policy and publications context

The following reports are relevant to the agenda and will be referred to in the following summary by their references (#1 etc.). The following assumes that these documents provide useful guidance, despite the fact that the majority were published by the previous administration.

#1 Social Exclusion Unit (2004) *Mental Health and Social Exclusion* London: Office of the Deputy Prime Minister

#2 Department of Health (2006) *Vocational services for people with severe mental health problems: Commissioning guidance*

#3 Seebohm, P and Grove, B (2006) *Leading by Example* London: Sainsbury Centre for Mental Health (not actually a government policy paper, but a significant statement)

#4 Department of Health (2008) *Refocusing the Care Programme Approach policy and positive practice* London: Department of Health.

#5 Perkins R, Farmer P & Litchfield P (2009) *Realising Ambitions: better employment support for people with a mental health condition* London: Department of Work and Pensions.

#6 HM Government (2009) *Work, Recovery and Inclusion* London: National Mental Health Development Unit.

#7 HM Government (2009) *Working our way to better mental health: A framework for action* Cm 7756.

#8 Department of Health (2010) *Realising the potential: the IAPT programme at full roll out* London: National Mental Health Development Unit, and particularly including *Annex 5.*

#9 HM Government (7 Dec 2009) *New Horizons: A shared vision for mental health* Cross government strategy: Mental Health Division.

Summary

This document provides a summary of what policy and good practice indicates should be done at a local level to help support people with mental health issues into paid work and covers the following:

1. Evidence of the need for an intervention, such as comparative employment rates for the population at large and people with mental health issues, prospects for obtaining work after receiving a diagnosis or admission to hospital, impact of unemployment on general health and use of health and social care services. (#1, #5, #6, #9). Balance investment across various eligible groups in society (#5).
2. Business case for the intervention – showing how investing in employment support is financially beneficial for employers, the mental health service and the Exchequer (#5, #6).
3. Value base (#6) and research evidence on what works – indicating what type of intervention is needed to deliver results. (#2, #5, #8). Disinvest in interventions that don't work (#5)
4. Coordination of provision – to ensure that there are no gaps or duplication between services and people move forward without delays or diversions. (#2, #7)
5. Mapping current provision and monitoring its effectiveness – to find out if changes need to be made. Implementing those changes in collaboration with stakeholders (#6)

In more detail...

The following paragraphs list all the things that should be happening to increase employment opportunities for people with mental health issues, as drawn from the policy documents listed above. The directives are grouped in the following sections:

- Reach the whole economy
- Commission effectively
- Lead by example
- All mental health staff are employment aware
- Clear role for vocational specialists
- Work in partnership

Reach the whole economy

1. **Challenge stigma.** Address mental health stigma and low expectations and link with national programmes (#5, #6, #7), such as Mental Health First Aid (#5, #6).
2. **Mentally healthy workplaces.** Encourage employers to prioritise promoting and managing mental well-being for all through effective recruitment, line management, absence management and return to work plans (#7). Also to stop inappropriate use of pre-recruitment health enquiries where it occurs (#5, #6, #7).
3. **Permanent jobs everywhere.** A range of job options (i.e. sectors of the economy) are supported, the majority of which are permanent (#2)
4. **Different ways to work.** Promote social enterprises (#6). 10-15 places in social enterprises per 100,000 population that offer job contracts on NMW or better and where employees are involved in business decision-making (#2). Self employment is an option (#5, #6).

Commission effectively

1. **Develop the market.** Increase private and voluntary sector role in provision of employment support (#2)
2. **Commission sufficient employment specialists.** There need to be employment specialists for in-house posts (1.0 whole time equivalent (wte) per LIT or PCT) and for other employers (1.0 wte per Community Team) (#2). Employment specialists do not do other things (#2) and carry a caseload of 25 or below (#2). Everyone with Severe Mental Illness has access to employment specialist 1.0 wte per Community Mental Health Team (CMHT) (#2). In population terms this is one employment specialist in primary care per 50,000 general population (#5). Mental health services to resource Individual Placement and Support (IPS) services, while the Department of Work and Pensions (DWP) ensure Jobcentre Plus (JCP) is accessible to people with lower level mental health support needs (#5)
3. **Create a pathway.** Improve the local vocational pathway (#7), including from volunteering to paid work (#5). Ensure 'vocational services' are actually about paid work and commission on the basis of vocational outcomes (#5), testing IPS against the fidelity model (#5).
4. **Commission for outcomes.** PSA16 required year on year increase in numbers of people with mental health issues accessing paid employment (#2)
5. **Integrate with other initiatives.** From October 2010 government plans to begin eight Right to Control trailblazers in England. These will design and test new opportunities for disabled people to exercise much greater choice and control over the support they receive to help them return to or stay in work. The trailblazers will run for two years and be evaluated to determine how these principles can be implemented more widely. (#7). Extend successful approaches to other client groups as appropriate (#5) and factor MH employment outcomes into contracts for other services (#6). Ensure vocational plans are not blocked by other elements of the way that the health and social care system functions (#5). Ensure that a range of options in place so referrals to IPS are appropriate (#2).

Lead by example

1. **Mental health** service is exemplary employer (#2, #3) alongside the remainder of the public sector (#6).
2. **Policies** in the mental health service reflect a commitment to employ service users (#2, #7) and offer internships (#5).
3. **Monitoring** captures job outcomes for people on the Care Programme Approach, jobs in public services and proportion of posts that are permanent. Service users are involved in monitoring. (#2, #5) Monitoring also includes employment outcomes from the Increasing Access to Psychological Therapies (IAPT) service (#8).
4. **A senior manager** is identified to lead on employment issues, along with one clinical lead in each CMHT (#2).

All mental health staff are employment aware

1. **Work is everybody's business.** All professionals are involved in promoting **w**ork (#2) and prioritising paid work within a spectrum of meaningful occupations (#2). They sequence options as first mainstream employment and education, then mainstream voluntary work, then integrated community activities. (#2). They encourage people to follow the steps to wellbeing (#7).
2. **Positive and hopeful approach.** Mental health workers enquire about the employment status and aspirations of service users (#2). They are positive and hopeful about employment (#2, #5) as revealed by the low proportion of people using their services who consider themselves unemployable (#5). Staff promote a public consensus that work is good for mental health and well-being (#7). Continuing professional development for staff includes the development of knowledge and skills about the positive impact of employment on mental health and how to support vocational aspirations (#2, #5).
3. **Care Planning.** Care plans and CPA reviews should include vocational planning from the outset (#2, #4, #5) the financial incentives of being employed are well understood and communicated (#7). Planning with

people may involve developing an employment-related Wellness Recovery Action Plan (#4, #5).

4. **Personalisation**. Staff encourage the use of personal budgets and personal health budgets to fund employment support for people with severe mental health problems (#6) within the context of the Right to Control (#6).

Clear role for vocational specialists

1. **Trained.** They need to be appropriately trained (#5)
2. **Integrated with clinical work.** Vocational programmes should be integrated into the clinical team (#2, #5, #8) and vocational specialists must attend treatment meetings (#2). They need to meet together as a group, share information and help each other (#2, #5).
3. **Prioritise IPS.** They have a good knowledge of IPS (#2) and strongly prioritise it as an intervention (#5, #6) whilst maintaining model fidelity (#5). As a result, programmes should involve minimal pre-vocational training (#2) and focus on paid employment in permanent jobs (#2).
4. **A spectrum of options.** However, the focus on IPS is not to the complete exclusion of other vocational options that may help people who may not benefit from IPS (#2, #6).
5. **Types of help.** They focus on career planning, not just job placement (#2), negotiate reasonable adjustments (**#5**), support people's rights under the Equality Bill (#6, #7) and give a rapid response to employers to keep people in their jobs (#5). They, along with their IAPT colleagues, access accurate benefits advice and better off in work calculations (#5, #6, #7, #8). They help people think through their options on disclosure of their mental health condition to their prospective or current employer (#5)..

Choose who to help

1. **A twin approach.** Work with both employee and employer, offering time-unlimited support (#2) that is personalised (#5, #8) but can be expected to taper (#5).
2. **Avoid erecting barriers.** Anyone who chooses to work is helped to do so (#2). Transitions from secondary to primary care should not disqualify people from employment support (#5). Include job retention work and liaise with primary care (#2, #6, #7, #8), partly through collaboration with employee assistance programmes (#6). People with severe mental ill health in primary care get same access to support and GPs can refer (#2).
3. **Target some people.** Target people newly on Incapacity Benefit (#2). Provide advice to newly unemployed people (#7). Help people facing the greatest barriers to employment (#2) although the costs of support for some people may be prohibitive (#5). Focus on people using secondary mental health services (#2). No eligibility requirements or exclusions such as job readiness, lack of substance abuse, history of violent behaviour, learning disability or mild symptoms. (#2) Assertive outreach to people who disengage from the employment service (#2)
4. **Early intervention.** Get back to work asap and move from supported to unsupported arrangements whenever appropriate (#2).
5. **Promote independence.** Aim for progression to unsupported employment, where appropriate, and independent living. Work Choice will also offer ongoing in-work support to those people who cannot move into unsupported employment. (#7). The Government plans to improve permitted work arrangements (#7) with the aim that a proportion move off into ordinary work (#5).

Work in partnership

1. **Through a forum.** Vocational Forum in place in each LIT/PCT area meeting quarterly, well attended and productive, including work shadowing between MH and JCP (#2). Build peer support opportunities for jobseekers and employees with mental health issues, and for employers (#5).
2. **With people who use services.** People should be full partners in policy and service development (#6).
3. **With DWP.** Link with DWP Health, Work and Well-being Coordinators who champion integrated approaches to health, employment and skills support, encourage local public sector employers as exemplars and build engagement with small businesses at a local level. (#7). DWP to create internships – short term unpaid work tasters (#5, #6).
4. **With Jobcentre Plus.** JCP and MH service meet regularly (#2, #4, #5, #8). The MH service has good links with JCP Mental Health Employment Coordinators (#7). JCP tracks effectiveness of programmes for jobseekers with MH conditions (#5, #7). Improve MH understanding amongst JCP staff (#6, #7) through skills based training (#5) and as MH Coordinators help their DEA colleagues (#5). JCP offer better privacy and continuity of advisor (#5, #6) and personalised services (#6) with advance information about interviews (#6). JCP services include a redesigned and expanded Access to Work Programme (#5, #6, #7) with greater flexibility for mental health, and a new programme, Work Choice, which will replace WORKSTEP and place greater emphasis on supporting people who have mental health conditions (#6, #7).
5. **With Careers Guidance.** Work with specialist and mainstream advisers in the new Adult Advancement and Careers Services from 2010 who will ensure they provide good support to people with mental health issues (#6, #7).
6. **With HR and Occupational Health departments.** Strong links with Human Resources and Occupational Health services (#2,#5, #7).
7. **With Government.** Government has stated it will work with business and health services to provide better information about locally

available health and well-being advice, support and services, including business-to-business support and publicise good practice for mentally healthy workplaces (#6, #7).

8. **With employers.** Government has stated it will promote the use of return-to-work action plans agreed between employer and employee (#7).

9. **With GPs.** Ensure primary care is on board (#7) with access to employment focused IAPT services (#8). IAPT services focus on job retention, rapid return to work after sickness absence (through fit notes) and shortening periods of unemployment (#7, #8).

10. **With education, training and volunteering.** Links with learning, training and volunteering providers so that (1) they provide mentally healthy places; (2) participation leads on to paid work, and (3) people can upskill to respond to changing skills demands in the labour market (#6, #7). Support the acquisition of basic skills (#7).

11. **With schools and young people's provision.** The Government has stated it will consider how best to improve the experience of young people undergoing transition between children and young people's mental health services and services provided for adults, to ensure continuity of care for those who need it (#7). There is intended to be be a roll out of the Targeted Mental Health in Schools Programme to clusters of schools in all local authorities by 2011**.** Government has stated it will, subject to consultation, use new pupil-level well-being indicators to capture health and well-being outcomes and perceptions as part of the new School Report Card. They intend to strengthen the national Healthy Schools Programme, improve Personal, Social Health and Economic Education and make it a statutory part of the curriculum in schools as well as developing school health teams in every local area as part of delivering the Healthy Child Programme for 5 – 19 year olds (all in #7).