Manchester City Council  
Report for Resolution

Report to: Health and Wellbeing Overview and Scrutiny Committee – 12 January 2012

Subject: Update – Modernisation of Day Services

Report of: Stuart Hatton, Chief Operating Officer, Manchester Mental Health and Social Care Trust

Summary

The purpose of this report is to update Members on the modernisation of day services within Manchester Mental Health and Social Care Trust.

Recommendations

Members are recommended to:-
1. Note the progress with the modernisation of day services
2. Note the early discussions taking place regarding reablement
3. Note the degree of user engagement in the continuing development of the service
4. Note the future plans for this service

Wards Affected:
All

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Background Documents

None
1. Introduction

1.1 The intention behind the modernisation of day services was to develop a service for adults with severe and enduring mental health needs that creates opportunities and provides support to enable people to recover and promote social inclusion and mental well being. Whilst Manchester Mental Health and Social Care Trust had examples of innovative developments in its day services linking to mainstream opportunities and supporting the social inclusion of its service users, a lot of activity was still provided within building focussed mental health services which were failing to achieve social or vocational outcomes adequately.

1.2 As a reminder, a summary of the original proposal to modernise day services is included in Appendix A.

1.3 Elements of the day service, namely the three ‘day centres’, are funded by Manchester City Council via the Joint Commissioning Team within NHS Manchester utilising the pooled fund.

1.4 The main criteria for the modernisation were that services need to:
   - Be of high quality, equitable, accessible, responsive and timely
   - Deliver outcomes for individual service users, as defined by them and that support personalisation and choice
   - Be in line with the direction of local and national policy drivers
   - Use resources in the most effective and efficient way possible ensuring value for money

1.5 The envisaged benefits of the proposed service development were:
   - A new, evidence based service model, in line with Trust objectives and local and national policy expectations
   - A clear purpose for meaningful occupation and vocation within the Trust’s care pathway based service offer
   - An increased number of people supported to be active citizens and connect with their local communities with improved outcomes
   - More local and timely access to services
   - An increased number of service users receiving support to move into employment and mainstream services
   - Development of volunteering opportunities
   - Improved governance arrangements and systems to monitor and evidence the service impact and outcomes achieved

2. Background

2.1 At the Health and Wellbeing Overview and Scrutiny Committee on the 21st July 2011, the Chief Operating Officer of Manchester Mental Health and Social Care Trust presented a report, which provided members with information about the Trust’s modernisation of day services for adults with severe and enduring mental health needs.
2.2 The committee welcomed the modernisation, particularly the focus on providing a personalised service to service users to support their recovery and, the work done to address the concerns of those service users that did not want changes to be made.

2.3 The committee asked that a progress report be provided regarding the modernisation of day services early in 2012.

3. Modernisation Update

Eligibility

3.1 The modernised service, (the Recovery Pathways Service, Wellbeing through Art, People and Places), continues to have the same eligibility criteria as was previously in place, which is for those:

- adults with severe and enduring mental health problems who are subject to the Care Programme Approach (CPA) or entitled to a service under Fair Access to Care Services (FACS) operated by Manchester City Council.

3.2 Further details of FACS definitions are available in Appendix B.

3.3 For those service users that through the review process are identified as not meeting the service eligibility criteria we will ensure that their needs and risks are recorded and goal plans agreed with these individuals and support provided to them to move through the service into outcomes of their own choosing. These service users will be supported to progress over the coming 12 months.

3.4 We have established a baseline of existing service user’s eligibility and funding in relation to individual budgets. From a total of 108 potentially eligible for an individual budget, less than 10% have an up to date individual budget. This is mainly due to a lack of clarity regarding which elements of the modernised service require an individual budget. Options are being considered and discussions with the Local Authority Commissioners are reaching a conclusion regarding which elements of the Recovery Pathways Service require eligibility for social care services and therefore application of individual budgets and the Fairer Charging Policy.

Demand for a Modernised Service

3.5 The Recovery Pathways service has continued to develop a number of activities and opportunities to support the recovery, social inclusion and improve the wellbeing of service users. The service is broken down into Creative Wellbeing via the Studio One and Start teams, Green Wellbeing, Employment Support, Recovery and Connect, Occupational Therapy and Benchmark.

3.6 Service users are engaging with the Recovery Pathways service. In December 2010, prior to modernisation, the service had an overall caseload of 418, as of the 21st December 2011 the modernised service has an overall caseload of
567 which represents a 36% (149) increase. We expect this demand to continue to increase as the service develops.

3.7 We have commenced a review and goal setting process with service users to ensure that we identify their health and social care needs that the Recovery Pathways service aims to address. To date 45% of service users have completed this process. We will aim for all service users to have had a review meeting and goal plan agreed by the end of March 2012 and will then apply a 12 week review cycle. As part of this process all service users will be offered the opportunity to complete a Warwick and Edinburgh Mental Wellbeing Scale as a way to enable their personal reflection and provide evidence of the progress that service users make whilst being supported by the service.

3.8 Prior to implementation of the changes, concerns were raised from some service users, carers and user groups regarding the potential negative impact that the proposed changes would have on service users, in particular those previously accessing the Mainway service. From a total of 91 potential service users, 68 Mainway and Horticulture service users have taken part in a needs assessment/review meeting and a follow up meeting and have been allocated a Recovery and Connect worker or allocated to new activities. Of the original 91 service users, 23 individuals have not taken up the offer of the new service either due to them not being active users or their needs being met in other ways.

**Use of Facilities**

3.9 We are undertaking a refurbishment of the building which formally housed the Mainway service. Through joint planning with service users and carers, this investment will result in a fit for purpose space that will include an art room, multi use group room, a reception area, a break out area and a food preparation kitchen to enable service users to get involved in the preparation of food for sale in the Orangery café (located in Park House reception area). We have temporarily relocated activities to the Harpurhey Wellbeing Centre and aim to deliver activities from the refurbished space from March 2012 and will commence engagement with service users and carers regarding this in February 2012. The activities on offer will be open to Recovery Pathways Service Users and we will work in partnership with Inpatient services to enable their service users to access opportunities on offer as part of their care pathway.

**Creative Wellbeing**

3.10 Within Creative Wellbeing a number of innovative service developments have taken place, one example being a partnership between Studio One and Manchester Art Gallery working on the Pre-Raphaelite experiment.

3.11 This involved service users from across the City working with the Manchester Art Gallery curatorial team, artists and musicians and exploring the Pre-Raphaelite collection. This project has achieved the following;
• encouraged wide community engagement  
• encouraged service users to become involved in the Art Gallery via its volunteer guide programme  
• created a valuable addition to peoples learning in community settings  
• raised the self esteem and wellbeing of service users

“I had a sense of achievement when I saw my paintings hung in the gallery and was overcome with emotion at the fact that I’d actually painted them”

“Working at Studio One made me feel part of the community around me”

“Working at Studio One made me feel confident in a way I haven’t felt like in a long time”

Recovery and Connect

3.12 The teams of Recovery and Connect Workers, based out of the three day centre buildings, have been working to support service users on a one to one and group basis, with their recovery, social inclusion and wellbeing. This has included supporting the service users who previously attended the Mainway service to meet their needs. We have evidence to show that for many of these service users the changes made to the service has led to positive outcomes as the vignettes below illustrate.

George attended Mainway for over 20 years, he carried out contract packing and travelled to and from the service via the Ring and Ride, organised for him by staff.

As part of the modernisation of the service George was allocated a Recovery and Connect Worker. George is now being supported to attend Harpurhey Wellbeing Centre and a bowling group in his local community. He has become more confident and is socialising with others in the group. George takes part in the photography group and visits places of interest in the community with the Out and About group. George is now able to arrange Ring and Ride for himself so that he is able to get to the places he wants to, at a time that suits him.

Fred attended Mainway for 8 months and during his time in the service worked on his own, producing art work.

Following service modernisation he now participates in an art class at Harpurhey Wellbeing Centre, sharing and discussing his work with the other participants and the tutors. He has been supported by a Recovery and Connect Worker to visit a Community Arts Centre and is now confident enough to go on his own and with friends and family. Some of his work is on display in the Community Arts Centre which has led to members of the public buying his artwork. He is now discussing with an Art Tutor the possibility of commencing an Adult Education course at College in September. Fred says that he “enjoys coming to the Wellbeing Centre” and he believes that the service is helping him to deal with this anxiety and has increased his confidence.
Employment Support

3.13 A key element of some individual’s recovery is employment and to address this need the Recovery Pathways service has three Employment Specialists who work to the evidence based Individual Placement and Support model of supported employment. This approach to tackling the worklessness of adults with mental health needs, supports the Local Authority with the achievement of the Public Service Agreement Targets (PSA 16) and the recent Social Care Outcomes Framework. The Employment Specialists have supported eleven service users into employment since the 1st April 2011.

3.14 Further details of the IPS model of supported employment are available in Appendix C.

Green Wellbeing and Bite

3.15 We are continuing to develop the Veg Bag scheme in partnership with Manchester Mind, at the North Manchester General Hospital Green Wellbeing base. This activity is currently available every Wednesday with a view to increasing this once orders increase and systems and processes are refined. This activity is well attended by service users who are involved in driving, collecting vegetables, quality control, weighing, bagging, distribution and customer service. We are increasing the staffing resource into this development and have been successful in securing additional funding from the North West NHS Social Value Innovation Fund to support this development.

3.16 The partnership between the Recovery Pathways service and North Manchester Health Forum continues in relation to the Wellbeing Centre in Harpurhey and we have secured some additional funding from Ground Work North West to support the projects sustainability

Benchmark

3.17 Work is underway regarding the potential of the Benchmark service establishing as a social firm. An integrated business plan is being developed to explore the viability of this proposal for consideration by the board of MMHSCT. We are working through a process of due diligence to provide an assurance that this is in the best interests of all concerned. It is envisaged that the Trust will support Benchmark via a contract, to continue to provide opportunities for service users to build relevant personal and work skills and from this, work towards a range of outcomes including employment. The contract with Benchmark will be for a service that will promote recovery and social inclusion by the provision of structured and goal focussed activities, centred around DIY and woodwork:

4. Working with service users and carers

4.1 A service development group met for the first time on the 20th June 2011. This involved staff, service users and carers of the ‘North’ service patch. 11 service users and carers attended the meeting and discussions included the
activity programme, ideas for new activities, communication and building issues. Although this was overall an immensely positive meeting and it is clear that engagement had started to take place, we feel that we need regular user and carer engagement at both a strategic and local level.

4.2 We are now planning a Service Development Steering Group, led by the Associate Director for Social Care and Inclusion. This group will provide a formal forum for service users, carers and staff to work together to ensure that the Social Inclusion Care Group delivers services that are underpinned by the principles of recovery, social inclusion and personalisation and work within the limits of allocated resources. This group will help to establish areas for further service development to support service users achieve outcomes.

4.3 At a more local level we are planning a series of Creative Experience and Feedback events, on a quarterly basis, to enable service users to provide feedback to us on what aspects of the service are supporting recovery, social inclusion and wellbeing and to generate ideas of how we can work to improve the service.

4.4 Service users and carers were involved in planning the refurbishment of the Mainway building through their attendance at meetings, held with a representative from the Estates Department and Recovery Pathways staff.

4.5 A video diary has been produced that documents the experience of 5 service users who previously attended the Mainway service and are now part of a photography group at Harpurhey Wellbeing Centre.

5. **Workforce Impact**

5.1 The majority of staff from the previous day services moved into posts in the new structure. A few posts remain vacant and are in the process of being recruited to. Despite our best efforts to mitigate against redundancy, five members of staff have been made redundant.

5.2 TUPE staff have been maintained on their existing Terms and Conditions. Ongoing discussions will take place with these staff to ensure that this arrangement does not impact negatively on any staff.

6. **Next Steps**

6.1 Early discussions are taking place between the Trust and the Local Authority regarding the development of a mental health reablement service and how the Recovery Pathways Service can help people to increase their levels of independence, recovery and social inclusion, and in turn reduce the need and associated costs for higher care packages of care and provision of community care services.

6.2 We are planning to develop improved outcome monitoring so that we can evidence the success that service users achieve with the support of the Recovery Pathways service.
6.3 We are developing Start2, an online creative wellbeing service that will enable a wider audience to benefit from the model of working developed in the Start team which uses creativity to develop self care strategies aimed at maintaining and improving wellbeing. The online service will offer over 60 diverse interactive exercises to enable people to improve and maintain mental wellbeing through creativity based exercises. The service will contain a validated outcome measure based on the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). The ‘Wellbeing Thermometer’ has been put together with guidance from Psychologists and Psychiatrists. Thus the thermometer provides a indication of each user’s wellbeing over time, allowing personalised action plans and suggested activities.
Appendix A:

Summary of Day Service Modernisation Proposal

Introduction

The Social Inclusion Care Group proposed to develop the Trusts day service provision, from a building based approach, to a service that creates opportunities, provides support to enable people to recover and promotes mental well being.

The envisaged benefits of this proposed service development over the previous service provision were:

- A new evidence based service model, in line with Trust objectives and local and national policy expectations
- A clear purpose for meaningful occupation and vocation within the Trusts care pathway based service offer
- An increased number of people supported to be active citizens and connect with their local communities with improved outcomes
- More local and timely access to services
- An increased number of service users receiving support to move into employment and mainstream services
- Development of volunteering opportunities
- Improved governance arrangements and systems to monitor, evidence impact and outcomes achieved

Mental health is not simply the absence of mental illness. People with mental health conditions can have a positive state of well-being, and vice versa. The day service modernisation aimed to provide services that promote purpose and participation, generate a positive outlook, improve wellbeing and give opportunity for creativity and purposeful community engagement.

Challenges

Quality, Innovation, Prevention and Productivity need to be at the heart of all services, and this modernization aimed to deliver a service that would be cost effective and evidenced based, have efficient monitoring systems in place, engage people in their own personal recovery and evidence progress made and outcomes achieved.

Whilst we had examples of innovative developments in our day services linking to mainstream opportunities and supporting the social inclusion of our service users, a lot of activity was still provided within building focussed mental health services which failed to achieve social or vocational outcomes adequately.

Previous Arrangements

This proposal impacted on the services historically referred to as Community Living services, namely;
These services were a disparate group of services which lacked clarity, consistency and equity. Feedback from some referring Care Co-ordinators suggested they were not clear what the services had to offer and the referral system was unclear, which presented a risk of service user needs not being met. There was a low level of demand for the services; in December 2010, 418 service users were accessing the service. It was anticipated that the proposed service modernisation would increase the capacity of the service by 75% enabling access for approximately 900 service users. This would be achieved via the standardization of caseload numbers for Recovery and Connect Workers, structured activities leading to an increase in session places available and a more personalized service that would be attractive to a wider service user audience.

**Proposed Service Model**

This proposal recognized that in order to give people choice, a range of options needed to be provided that included long term support for some people and working at peoples own pace. Individuals need to be able to set objectives that are reflective of their personal journey of recovery.

This proposal aimed to meet the needs of service users and carers, and to enable staff to provide a quality service. It was proposed that the Recovery Pathways service be developed across the city, building on existing services and developing these further. All activities on offer would have a focus on recovery, social inclusion, wellbeing and skills development and form part of a person’s care pathway. The activities on offer would provide routes for progression within the service as well as preparing service users for progression outside of the service.
In order to address the inequality and inconsistency that existed with regard to assessment and goal planning, it was proposed that the service would adopt a standardized approach to assessment and goal planning and monitoring of service user progress. In addition the Warwick-Edinburgh Mental Wellbeing Scale will be used to measure improvements in people’s mental wellbeing).

The Pathway

Get to know you, recovery star, goal plan and WEMWBs → Engage in activity with ongoing support → Ongoing review and goal planning → Progress onto outcome of your choice

It was proposed that all activities would have a continuum through which a service user would progress. Dependent upon the service user needs, the pace at which someone moves through the services will differ, but as a standard the initial phase of activity will last for a maximum of 12 weeks, (based on the successful testing of this approach in the Start service). Following this time period (or sooner if appropriate), the first review will take place, a new goal plan agreed and the next period of activity will begin, the focus always on progression towards recovery and inclusion and reablement via skills development.

Stakeholder Engagement

The proposal was shared widely with a range of stakeholders. Specific involvement and engagement with service users and carers took place. The intention was to achieve meaningful engagement, through sharing the proposal, listening to comments and gathering feedback and making amendments to the proposal where appropriate. An engagement plan was produced to support this process. Consultation with directly affected staff was undertaken in accordance with the Trusts Organisational Change policy, and was detailed in a staff consultation paper.
Appendix B

Fair Access to Care Services (FACS) Criteria
The eligibility framework is graded into four bands, which describe the seriousness of the risk to independence and well-being or other consequences if needs are not addressed. The four bands are as follows:

Critical – when
- life is, or will be, threatened; and/or
- significant health problems have developed or will develop; and/or
- there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or
- serious abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- vital involvement in work, education or learning cannot or will not be sustained; and/or
- vital social support systems and relationships cannot or will not be sustained; and/or
- vital family and other social roles and responsibilities cannot or will not be undertaken.

Substantial – when
- there is, or will be, only partial choice and control over the immediate environment; and/or
- abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- the majority of social support systems and relationships cannot or will not be sustained; and/or
- the majority of family and other social roles and responsibilities cannot or will not be undertaken.

Moderate – when
- there is, or will be, an inability to carry out several personal care or domestic routines; and/or
- involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- several social support systems and relationships cannot or will not be sustained; and/or
- several family and other social roles and responsibilities cannot or will not be undertaken.
• **Low - when**
  • there is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
  • involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or
  • one or two social support systems and relationships cannot or will not be sustained; and/or
  • one or two family and other social roles and responsibilities cannot or will not be undertaken.
People who experience severe and enduring mental health problems have one of the lowest employment rates in the UK. Yet the vast majority want to work, and with the right support many people can.

We know from international experience and research how to offer effective support to enable people with mental health problems to work. Large numbers of people have and can be supported to secure and maintain paid competitive employment through Individual Placement and Support (IPS).

Individual Placement and Support has seven key principles, each of which is needed for the service to work well. They include focusing on paid employment of an individual’s choice, not sheltered work or lengthy job preparation, and support that continues once the person gets a job and that is provided together with clinical care and welfare benefits advice. The service should be individual to a person’s needs and wishes; offer rapid placement in work; and provide ongoing support for as long as it is needed.

Evidence about the benefits of IPS has been collected in response to the aspirations and the rights of people with mental health problems to receive high quality, evidence-based supported employment services. It is clear that IPS is effective and should be available to all who can benefit from it. The opportunity to work should be recognised as an integral part of recovery and of treatment for mental ill health. This briefing outlines the evidence base for IPS and provides information on how to ‘do what works’.
Introduction

Work is good for our physical and mental health. Unemployment has been shown to damage our health (Waddell & Burton, 2006), while participation in work can play a vital role in recovery for many people with mental health problems (Borg & Kristiansen, 2008; Shepherd et al., 2008). Yet people with severe and enduring mental health problems are less likely to be in paid employment than any other disadvantaged group. The average employment rate for the UK working age population was 74.2% between August and October 2008 (Labour Force Survey, 2008). By contrast, only 22% of respondents to the 2008 Healthcare Commission survey of people using specialist mental health services said that they either had paid work or were in full-time education.

The majority of people with mental health problems (70-90%) consistently say that they want to work (Grove, 1999; Secker et al., 2001). Many people are able to work and pursue careers, if properly supported. Diagnosis is a poor indicator of employability. Work history and length of time employed are better indicators, but the overriding predictor of success is a strong desire to work (Grove & Membrey, 2005).

Supporting people with mental health problems into employment should be a top priority for health and social care providers and commissioners. Yet only half of mental health service users report having received any help with employment (Healthcare Commission, 2008). This may reflect the low expectations many professionals have about the prospects of employment for people with mental health problems (Rinaldi et al., 2008; Marwaha et al., 2008).

There are barriers to employment which are real and should not be denied (Sainsbury Centre, 2007) but with the right support they can be overcome. Whatever the perceived difficulties, and whatever the economic conditions, real work still represents the most effective treatment for mental health problems (Drake, 2008).

There is strong evidence that Individual Placement and Support (IPS) is the most effective method of helping people with severe mental health problems to achieve sustainable competitive employment. It consists of intensive, individual support, rapid job search followed by placement in paid employment, and time-unlimited in-work support for both the employee and the employer.

The principles of IPS have been strongly endorsed by the Social Exclusion Unit (2004), in the Department of Health’s commissioning guidance on day and vocational services (DH, 2006a & 2006b) and in the Government’s action plan for social exclusion (Social Exclusion Task Force, 2006).

This briefing paper describes the key principles of IPS, presents an overview of the research evidence and provides information on further reading.

How does it work?

There are eight key principles of Individual Placement and Support. They are summarised in Box 1.

Box 1: The key principles of Individual Placement and Support (IPS)

1. Competitive employment is the primary goal;
2. Everyone who wants it is eligible for employment support;
3. Job search is consistent with individual preferences;
4. Job search is rapid: beginning within one month;
5. Employment specialists and clinical teams work and are located together;
6. Employment specialists develop relationships with employers based upon a person’s work preferences;
7. Support is time-unlimited and individualised to both the employer and the employee;
8. Welfare benefits counselling supports the person through the transition from benefits to work.

(Adapted from Dartmouth IPS Supported Employment Center, 2011)
1. **Competitive employment is the primary goal**
   
The fundamental assumption should be that paid employment (part-time or full-time) is a realistic goal for everyone who wants a job. Placement in education and training may provide a ‘stepping stone’ for younger people and other forms of training might help some people, but the central goal of the service must always be paid employment.

2. **Everyone is eligible**
   
   There are no ‘eligibility criteria’ for entry into IPS programmes beyond an expressed motivation to ‘give it a try’. This should be irrespective of issues such as job readiness, symptoms, substance use, social skills or a history of violent behaviour.

   Research shows that wanting a job is overwhelmingly the most important factor for successful placement in paid employment (Grove & Membrey, 2005). If a person believes paid employment is possible, and they receive the help they think they need, then their prospects are good. If they are subject to lengthy assessments to determine their ‘job readiness’ and endless preparation of CVs and interview practice, then they will soon lose heart. People are ‘job ready’ when they say they are and that is the time to start.

3. **Job search is consistent with individual preferences**
   
   Working closely with someone’s personal interests and experience significantly increases the chances of them enjoying and retaining a job. “Do you want to work?” and “What do you want to do?” are therefore the key – and indeed often the only – important assessment questions.

4. **Job search is rapid**
   
   The job search should be started early (normally within one month). A positive, ‘can-do’ attitude should be cultivated in both staff and service users. Staff should act as ‘carriers of hope’ for recovery (Glover, 2002). Clear targets with dates for action need to be agreed and adhered to. Preparation should be concurrent with job search.

5. **Employment specialists and clinical teams work and are located together**
   
   One of the most crucial aspects of the IPS approach is the quality of joint working between employment specialists and mental health teams. Employment specialists should be integrated, and preferably co-located, with clinical teams, irrespective of who employs them. They should actively take part in assessment meetings, influence referrals and share in the decision-making process. This may present a challenge to services that are more used to working separately, one after the other, i.e. ‘in a series’, rather than ‘in parallel’ together. It means that employment specialists must be central and equal members of the team, not peripheral ‘add ons’. In this way, the whole caseload of the clinical team is automatically the caseload of the employment specialist.

6. **Support is time-unlimited and individualised to both the employer and employee**
   
   The IPS approach makes getting a job the start of the process rather than the end point (it is ‘place-then-train’, rather than ‘train-then-place’). Thus, support must bridge this crucial transition and carry on for as long as is necessary. This means that individuals receive support that is based on their individual needs in relation to their job, skills and preferences. Support is provided by a variety of people including employment specialists, clinicians (e.g. to help people to manage their mental health in the workplace). Family members and close friends can be included in the team to support people in their working lives, if they wish. Employment specialists may also provide support to the employer in line with the individual’s wishes.

   Employment specialists should not require people to disclose their mental health problems to employers. Their role is to discuss the benefits and risks of disclosure and non-disclosure with the individual and support them in their decision.

7. **Welfare benefits counselling supports the person through the transition from benefits to work**
   
   It is essential that employment specialists or clinicians offer assistance in obtaining individualised benefits counselling to understand the financial implications of starting work. This should include the process of managing the transition from
welfare benefits to work and advice on in-work benefits such as Tax Credits. It is essential to have good relationships with specialist experts in Jobcentre Plus and other welfare benefit agencies, such as Citizen’s Advice Bureaux.

**What is the evidence?**

Randomised controlled trials (RCTs) across the United States, Canada, Hong Kong, Australia and Europe, including the UK, have compared the experiences of IPS participants with groups taking other approaches to vocational rehabilitation (i.e. services based on more traditional principles of ‘train and place’, which provided vocational training and job preparation before looking for competitive employment). Across research studies, sites that most closely followed the IPS approach achieved the greatest success with an average of 61% of participants being placed in competitive employment compared to 23% in sites that followed other approaches (Bond, Drake & Becker, 2008).

“In following people for 30 years and then following patients who are in dozens and dozens of research studies that are sent around, it’s totally clear to me at this point that there’s nothing about medications or psychotherapies or rehabilitation programs or case management programs or any of the other things that we study that helps people to recover in the same way that supported employment does.”

(Drake, 2008)

One study, EQOLISE, covered six European countries including the UK. It found that IPS participants were twice as likely to gain employment compared with traditional vocational rehabilitation alternatives (see Box 2).

IPS is focused on the individual who is looking for work. Far from being a rigid model that restricts services, the evidence should actively encourage a thoughtful, supportive, flexible response to each individual. It promotes creativity and open-mindedness in employment specialists and mental health teams to help people to get good job matches and individualised support. It relies on employment specialists having excellent knowledge of local job markets and the needs of employers. It relies on effective team-working between employment specialists, health professionals and the individual, and it focuses on what is important and meaningful for those people (Swanson et al., 2008).

**Box 2: Results from EQOLISE study**

- IPS participants were twice as likely to gain employment (55% v. 28%) compared with traditional vocational rehabilitation alternatives;
- IPS participants sustained jobs longer and earned more than those who were supported by the best local vocational rehabilitation alternatives;
- Better results were obtained by implementing IPS principles in full;
- The quality of partnership working between health and employment providers was a critical success factor. It is particularly important to deliver integrated packages of vocational and clinical support;
- Employment outcomes were influenced by local employment rates and benefit levels although IPS services were still more successful than standard interventions;
- There was no deterioration in people’s mental health as a result of taking up work;
- A proportion of IPS participants remain unmotivated or unable to maintain open employment but it is not possible to identify these people when they first join a programme. This shows that a policy of zero exclusion is essential.

(Adapted from Burns et al., 2007)

**How is IPS assessed?**

The key to recognising whether a service is offering evidence-based individual placement and support is to assess how well the clinical teams and the employment specialists are working together to implement the seven principles.
Research shows that those services which faithfully follow the principles of IPS get more people into employment than those services that do not (Becker et al., 2001, 2006; McGrew et al., 2005; Burns et al., 2007). A ‘fidelity scale’ has been developed to enable services to measure how well they are meeting the seven key principles of IPS in their work (Bond et al., 1997). The benefits of achieving high fidelity are summarised in Box 3.

Fidelity should be reviewed regularly and the results, along with recommendations for improvement, should be fed back to employment and clinical staff (see Killackey & Waghorn, 2008 and Porteous & Waghorn, 2007, for how this can be done in practice). Some items on the fidelity scale may be easier to achieve than others.

### Box 3: Advantages of obtaining a high score on the ‘IPS Fidelity Scale’

- **For people using services:** it means that they can be given a clear idea of what kind of service to expect, with a focus on their personal preferences and real jobs, good communication with clinical teams and an assurance that quality standards will be maintained.

- **For employment services:** it means that they can achieve the best outcomes possible and that their practice will be continually monitored and improved.

- **For health services:** it means that people’s health will be given proper attention, within an integrated package of care, and that this will lead to better clinical and vocational outcomes.

- **For commissioners:** it means that they have a clear service specification which they can be confident will produce the best possible employment outcomes compared with any realistic alternative. It is also cost effective and has a built-in check on quality.

(Adapted from Rinaldi, 2008)

Co-location promotes regular contact and aids communication. It avoids duplication of assessment and reduces drop-out rates, particularly as it removes practical barriers such as travel between different sites. It gives employment specialists the opportunity to start working with individuals at an early stage. It will also help people who are in employment to retain their jobs when they become unwell.

A framework of integrated services changes and improves both clinical and employment services, actively demonstrating to clinicians the value of work as a form of treatment as well as improving vocational plans by taking clinical considerations into account (Drake et al., 2003) (see Box 4 on page 6). It also ensures that there is no unintended screening out of people clinicians think are not ‘work-ready’.

### The importance of co-location

One of the seven principles of IPS is that employment support and clinical management should be integrated, not separated. This can be achieved in any set of organisational or financial arrangements as long as those who commission, manage and monitor the services understand the importance of adhering to the principles of IPS. The most efficient way to achieve this is for employment specialists, whoever they are employed by, to be full members of clinical teams, co-located for at least part of the week. They should actively take part in assessment meetings, influence referrals and share in decision-making and problem-solving processes. All employment and clinical team notes should be integrated and remain confidential to the individual, the employment specialist and the clinical team.

Implementing IPS in the UK

The use of the IPS approach within local employment services is increasing.

One example, now well established, is the work of South West London & St George’s Mental Health NHS Trust. Here, IPS services have produced positive results (Rinaldi & Perkins, 2007) and are currently being used in early intervention services for young people with first episode psychosis (Rinaldi et al., 2004).
Box 4: Benefits of co-location

- Better communication;
- Improved coordination and coherence in a person’s journey through the ‘system’;
- The process of seeking employment is sensitive to a person’s clinical needs;
- Concerns of clinicians can be directly addressed;
- Vocational information is incorporated into care plans;
- First-hand observation can convince mental health teams of the efficacy of the focus on employment;
- More effective engagement and retention;
- Better outcomes for the individual.

(Drake et al., 2003)

Doing what works

There have been some similar developments elsewhere, in both the statutory and voluntary sectors, but progress is slow.

Barriers to implementation include:

- A lack of knowledge of, or belief in, the research evidence;
- A lack of commissioning of IPS services;
- Employment is still not considered a priority for mental health services, or seen as a realistic goal for people who have experienced mental health problems;
- A lack of IPS trained practitioners, in both employment and health services.

These barriers can be overcome by:

- Wider communication across mental health and employment services about the research evidence base and what can be achieved;
- Targeted and clear commissioning of IPS services, ensuring one full-time employment specialist is available for each clinical mental health team;
- Ensuring that mental health services offer recovery-oriented services (Shepherd et al., 2008) of which employment is a central part;
- Ensuring employment services are focused on providing evidence-based support.

Implementation of IPS needs to be driven by senior managers in both commissioning bodies and provider organisations. They need a strong commitment to organisational change and capacity building as IPS requires changes in the thinking of many mental health teams and employment services and the will to make changes at every level.

‘Doing what works’ requires collaborative and sustained efforts by all of those concerned to ensure that the research evidence becomes firmly embedded within practice and that it makes a real difference to people’s lives.

IPS as a design principle for other programmes

The Government’s Pathways to Work and new Disability Employment Programme both share many of the aims of IPS and there is considerable overlap between the groups of people these programmes are intended to serve. The evidence suggests that the more closely these other programmes follow the IPS principles, the more successful they are likely to be. Sainsbury Centre is initiating a dialogue with those responsible for these generic employment programmes to explore how they can be more effective in supporting people with mental health problems.

Supporting the development of IPS in the UK

This briefing paper marks the beginning of Sainsbury Centre’s commitment to supporting the implementation of Individual Placement and Support (IPS) in the UK. Our work will include:

- The publication of Key Performance Indicators for monitoring the performance of employment support offered by specialist mental health services. The indicators will provide both a framework for local services to set and monitor development priorities and an outline service specification for commissioners. They have been developed with the support of the NHS Confederation’s Mental Health Network;
A brief paper on the financial implications of Individual Placement and Support for commissioners;

A dedicated area of our website with up-to-date information on the growing international research evidence and examples of implementation in the UK;

Intensive support to selected sites in the UK to help them to implement Individual Placement and Support locally;

A programme of collaboration to build an international learning and practice community.

Where can I get more information?

Sainsbury Centre wants to hear from you. Have you heard of the IPS approach? Are you looking to implement IPS in your area? What are your experiences? Do you have any questions or comments for our team? Email your questions and responses via our website www.scmh.org.uk/employment

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Individual placement and support into employment

Briefing 37: Doing what works

Individual placement and support into employment

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References


