Realising Ambitions: Helping people with mental health conditions to gain and sustain employment

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A view from several perspectives

- 30 years working in NHS developing evidence based programmes to assist people with mental health problems to gain and sustain employment
- 20 years working with a ‘severe’ mental health condition
- 15 years employing people with mental health conditions in the NHS

- Led independent review to Government *“Realising Ambitions: Better Employment Support for people with a mental health condition”* 2009 www.dwp.gov.uk/docs/realising-ambitions

- Chair of Equality 2025 UK cross Government strategic advisory group on issues relating to disabled people based in Office for Disability Issues at Department of Work and Pensions
- Consultant on the UK Department of Health ‘Implementing Recovery through Organisational Change’ programme
- External advisory member of the UK Government Inter Ministerial Group on Disability Employment
- A member of the UK Mental Health Strategy Ministerial Advisory Group
- Co-chair of the UK Ministerial Working Group on Equalities in Mental Health

Recognition of the importance of work in people's lives is not new ...

"Work is nature's best physician and central to human happiness"

Galen, Greek philosopher and physician, 172AD

"the absence of occupation is not rest, a mind quite vacant is a mind distressed"

18th century poet William Cowper, who himself experienced periods of mental illness throughout his life and was confined to an asylum for over a year

People need two things – love and work . Work *"binds the individual to reality"*

Freud, 1961

"Work is the closest thing to a panacea known to medical science."

Szasz, 1974

"The best thing you can do for someone with schizophrenia is to get them a job."

Drake, 2006

"Work is just about the only thing you can do for 8 hours a day"

20th century US novelist William Faulkner

"I felt this is the end of my life…"

(Sayce, 2000)

Being diagnosed with a mental health problem is a devastating and life changing experience ... the bottom falls out of your world

"Out of the blue your job has gone, with it any financial security you may have had. At a stroke, you have no purpose in life, and no contact with other people. You find yourself totally isolated from the rest of the world. No one telephones you. Much less writes. No-one seems to care if you're alive or dead ." (Bird, 2001)

"*For some of us, an episode of mental distress will disrupt our lives so we are pushed out of the society in which we were fully participating. For others, the early onset of distress will mean social exclusion throughout our adult lives, with no prospect of ...a job or hope of a futures in meaningful employment. Loneliness and loss of self-worth lead us to believe we are useless, and so we live with this sense of hopelessness, or far too often choose to end our lives."* (cited by SEU,2003)

Too many become '***I used to be ...'*** **people:**
people with a past but no present and no future

Appropriate employment can be central to recovery

- It links us to the communities in which we live and enables us to contribute to those communities (always being on the receiving end of help is a dispiriting place to be)
- It provides meaning and purpose in life
- It affords status and identity
- It provides social contacts
- It gives us the resources we need to do the other things we value in life
- It is good for our health – both physical and mental

"Returning to work has changed my life considerably and has been the single most significant part of my recovery. For the first time in four years:

- *I no longer feel like a second rate citizen*
- *I have an identity that is more than my diagnosis*
- *I feel valued for who and what I can contribute to society*
- *I have a regular income*
- *I look forward to getting up in the morning*
- *I work through my depressions instead of wallowing on the sofa in self pity*
- *I have friends/associates with common interests*
- *I am prepared to try new activities*
- *I have stopped having panic attacks*
- *I have felt confident in making my own decisions about my medication*
- *I have hope."*

(Nicola Oliver, 2011)

The right to work – a human right

Article 23 of the United Nations Declaration of Human Rights (1948)

"Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment."

Article 27 of the United Nations Convention on the Rights of Disabled Persons

Article 6 and 7 of the International Covenant of Economic, Social and Cultural Rights

… but a right denied

Most people with a mental health condition want to have a job – in the UK people with mental health problems have the highest 'want to work' rate of all disabled people (SEU 2003)

BUT few have the opportunity to do so

In the UK

- Overall employment rate stands at around 74%,
- The employment rate for disabled people in general is 47%,
- The employment rate for people with a mental health condition is 21%.
- The employment rate for people using secondary mental health services 13.5%

But can 'they' work?

Frequently asked question - what makes a person 'employable' or 'work ready'?

But is this the right question?

The research evidence

- **Characteristics of individuals like diagnosis, duration or severity of problems are not reliably associated with employment outcomes** … therefore there is no justification for selecting people on the basis of clinical history/diagnosis

- **The only individual characteristics that influence employment outcomes are 'motivation and self-efficacy** – whether the person wants to work and whether they think they can – and both of these are profoundly influenced by the expectations of others – particularly the 'experts' in employment and mental health/addictions services

There is strong evidence from at least 16 'randomised controlled trials' that with the right kind of support - *Individual Placement with Support evidence based supported employment* – at least 60% with serious mental health problems can successfully get and keep open employment

Long term outcomes are positive: 8-12 year follow up 100% had worked at least some of the time, 71% steady workers (Becker et al 2007)

European Randomised Controlled trials of IPS evidence based supported employment

(Burns et al, 2007):

Considered only those who had a diagnosis of schizophrenia for at least 2 years – compared with 'train place' alternatives

Results

- **Significantly more people receiving IPS gained employment:**
  - 55% receiving IPS vs. 28% in existing service
- **Significantly fewer people receiving IPS dropped out**
  - 13% receiving IPS vs. 45% in existing service
- **Significantly fewer people receiving IPS were admitted to hospital**
  - 20% readmitted in IPS vs. 31% in traditional service

What is the right kind of support?

The principles of Individual Placement with Support evidence based supported employment

1. **Do not select people on the basis of 'employability' or 'work readiness' –** help **everyone who wants to have a go**

2. **Integrate employment support with treatment (and social/personal care, housing etc.) -** treatment, rehabilitation and employment support must be done in parallel
   - employment expertise/employment specialists in clinical teams
   - employment integrated into the work of all mental health workers
   - employment a core part of treatment and support plans

3. **Focus on open employment** - real jobs – and a 'can do' approach

4. **Rapid job search** (start within 4 weeks) rather than stepping stones first. If training/ experience are necessary, these should be in parallel with job search NOT stepping stones first

5. **Job search must be personalised and based on client preferences** - a person is more likely to get and keep a job that is in line with their interests/preferences - and may involve active, individualised. work with employer

6. **Employers are approached with the needs of individuals in mind** – not just passive applications for jobs, but pro-active job finding

7. **On-going, personalised support to both employee and employer**: Employment involves a relationship between employee and employer and both parties may need support

8. **High quality assistance with in and out of work welfare benefits and financial planning**

Need to do all of these things to be effective – outcomes related to fidelity

It's not just research trials – IPS is effective in regular day to day practice

The experience of South West London Mental Health NHS Trust

Comprehensive community and inpatient mental health services for a population of 1 million people living in South West London (approximately 2600 staff serving 15,000 people at any one time)

- General adult mental health services (including inpatient wards, community mental health teams, assertive outreach and early intervention services)
- Addictions services

- Psychological therapy in primary care
- Mental health services for older people children and young people
- Forensic services
- More highly specialised services including services for Deaf adults and children, adolescent and adult eating disorder services etc.

Implementing 'Individual Placement with Support' in Community Mental Health, Addictions and First Episode Psychosis Teams

- 'Employment Specialists' recruited to work within Teams and increasing the focus on vocational issues in the care planning process
- Employment Specialists help people
  - to keep jobs they already have
  - to decide what they want to do and apply for the work they want
  - to access mainstream employment agencies
  - in the transition to work
- They also:
  - ensure that mental health professionals attend to work related issues in care plans
  - advise and assist other mental health workers in providing ongoing support
  - support employers and advise them on adjustments the person may need

South West London Outcomes

Employment Specialists in 11 South West London Community Mental Health Teams including the Community Drug Team (2007/8):

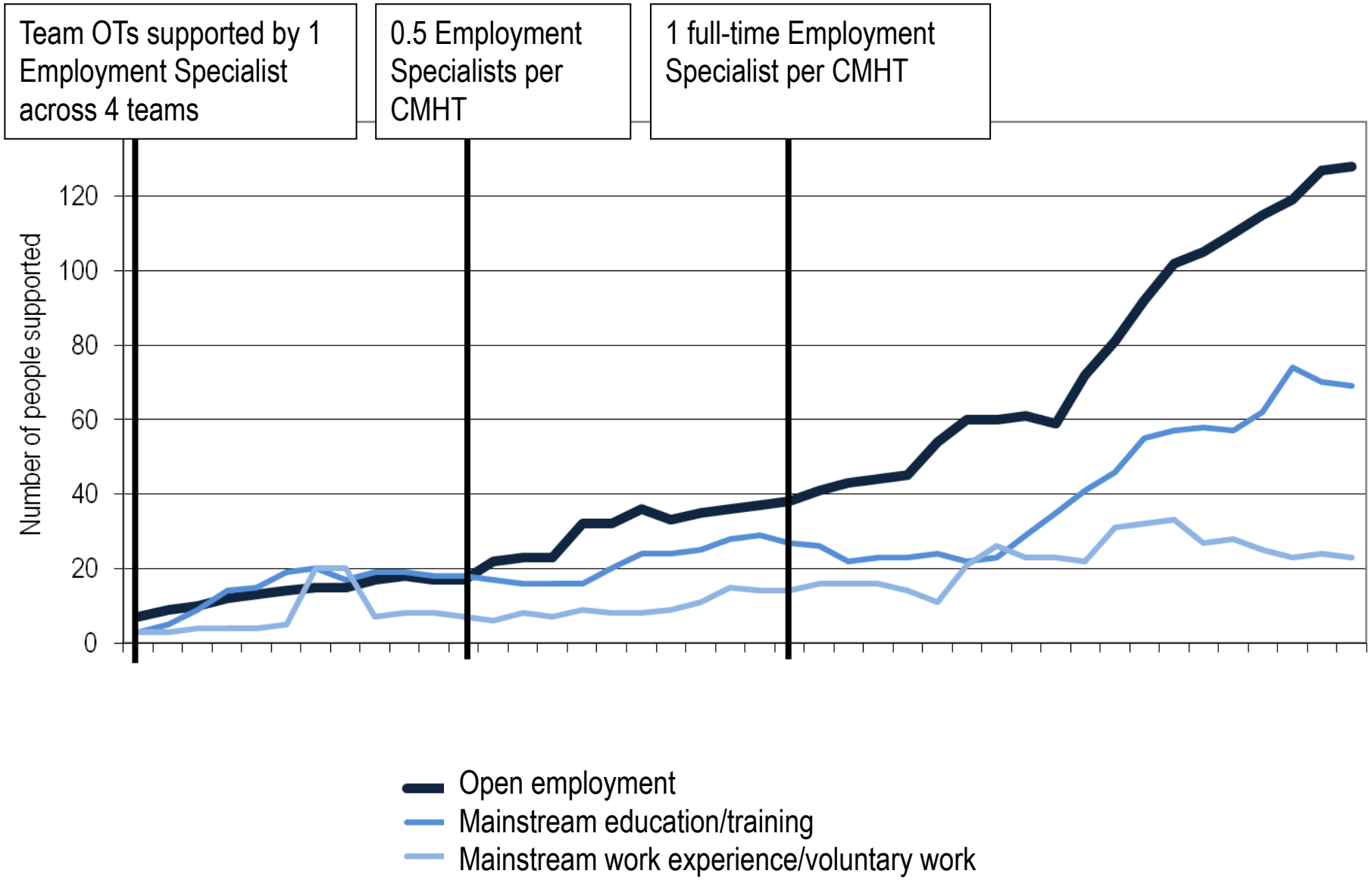
(60% had a diagnosis of psychosis)

1984 people received vocational support

1155 people successful in working/studying in mainstream integrated settings:

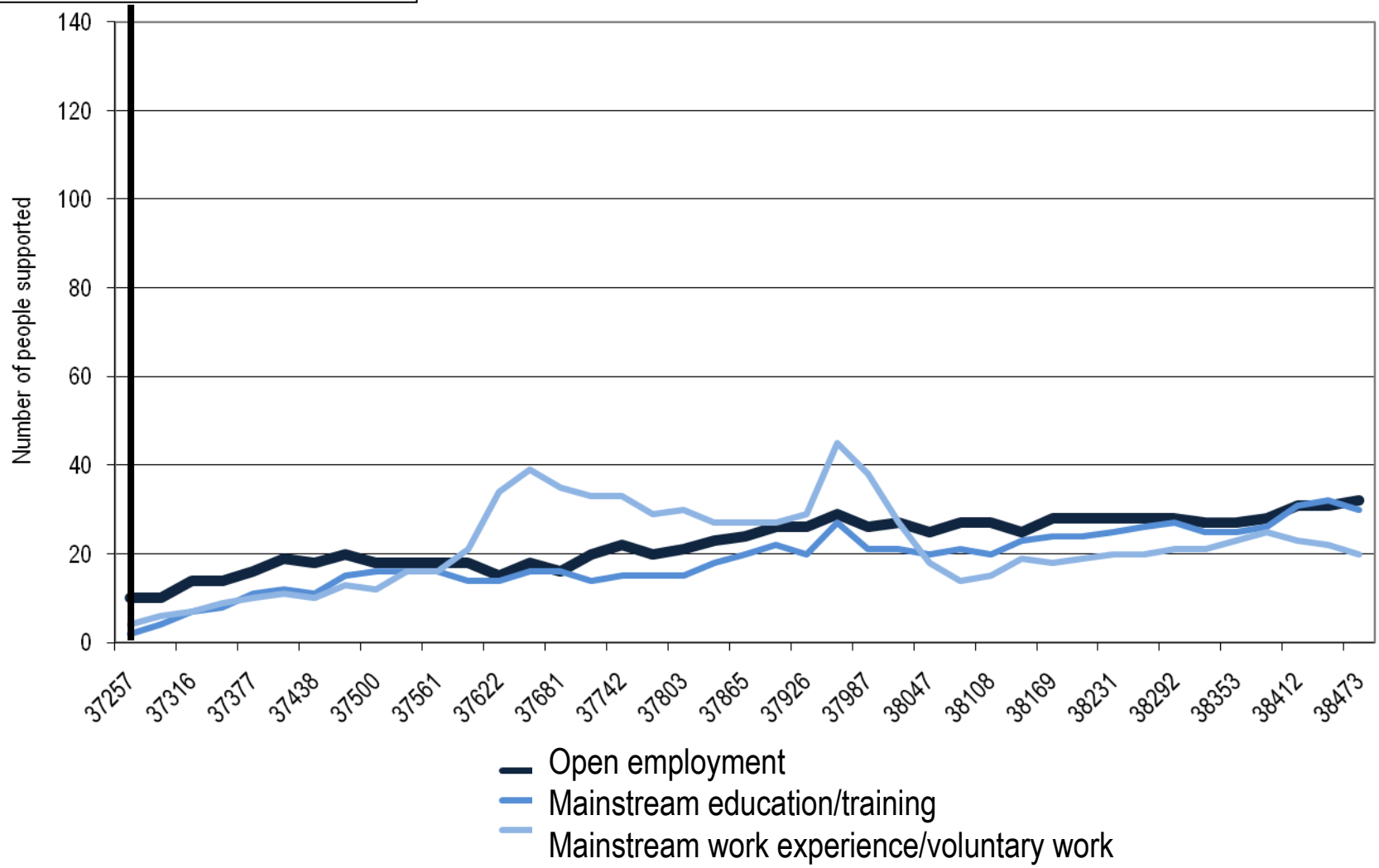
- 645 people supported to get/keep open employment
- 293 people supported to get/keep mainstream education/training
- 217 people supported in mainstream voluntary work

Number of people supported in employment, mainstream education and voluntary work in a London borough where IPS was implemented in all community teams



Number of people supported in employment, mainstream education and voluntary work in a London borough where IPS was NOT implemented

Team OTs supported by 0.5 Employment Specialist across 4 teams

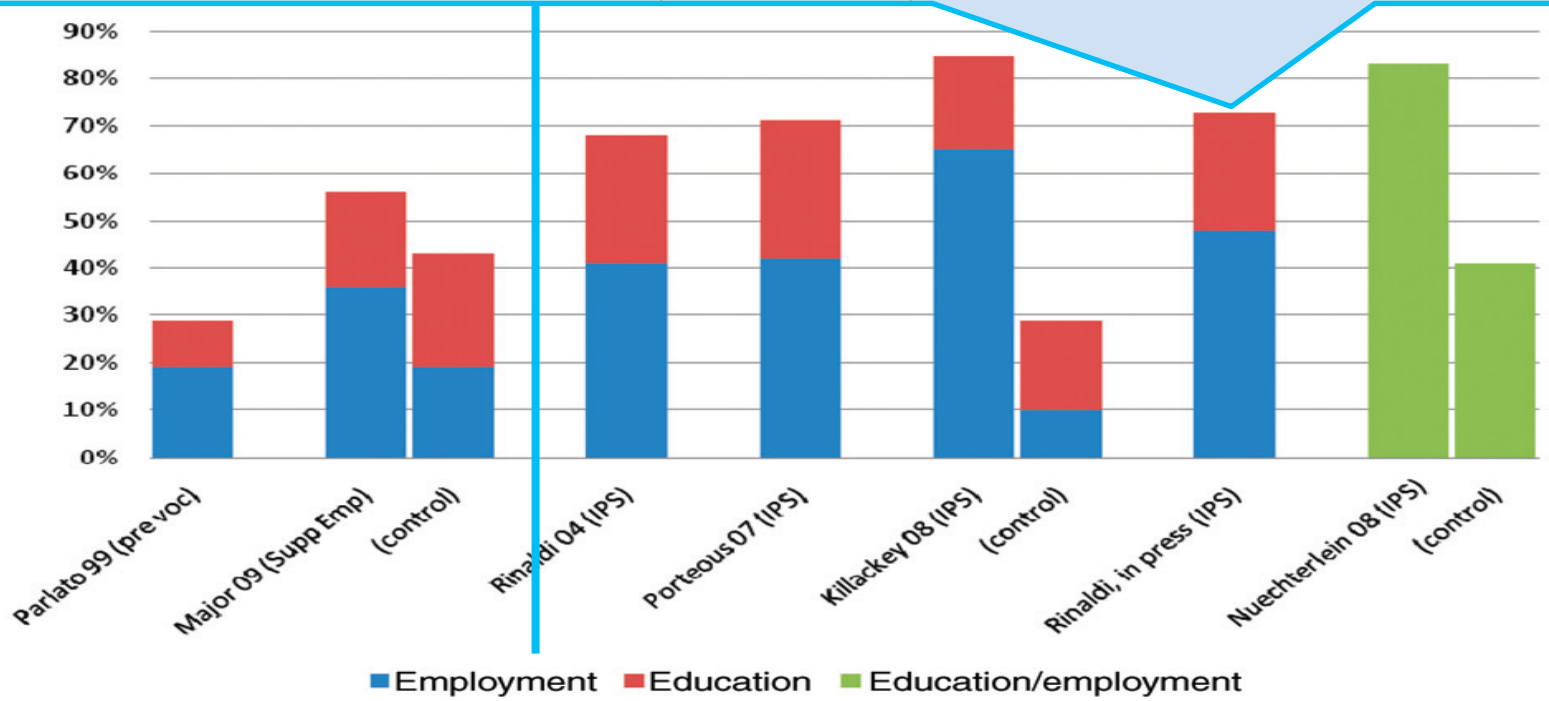


If we really address employment and education right from the start the results are even more impressive

Typical Picture: 50% in employment or education at first admission - only 20% a year later … but it doesn't have to be this way

Individual Placement with Support in First Episode Psychosis

South West London: (mean age 21 years)
After 2 years 73% in employment (48%) or mainstream education (25%)
(Rinaldi et al, 2010)



From Rinaldi et al (2010) First episode psychosis and employment: A review. *International Review of Psychiatry,* April 2010; 22(2): 148–162

And they were not all stacking shelves

Wholesale manager
Accountant
IT assistant
Mental health development worker
Ward assistant
Bookmaker
Call centre handler
Retail assistant
Receptionist
Hairdresser
MH advocate
Occupational therapy assistant
Accountants officer

Catering assistant
Chambermaid
Cleaner
Hotel Porter
Labourer
Leaflet dropper
Plumber's assistant
Post assistant
Recycling assistant
English Teacher
Actor
Journalist
Admin worker
Credit controller
Project worker (private sector)

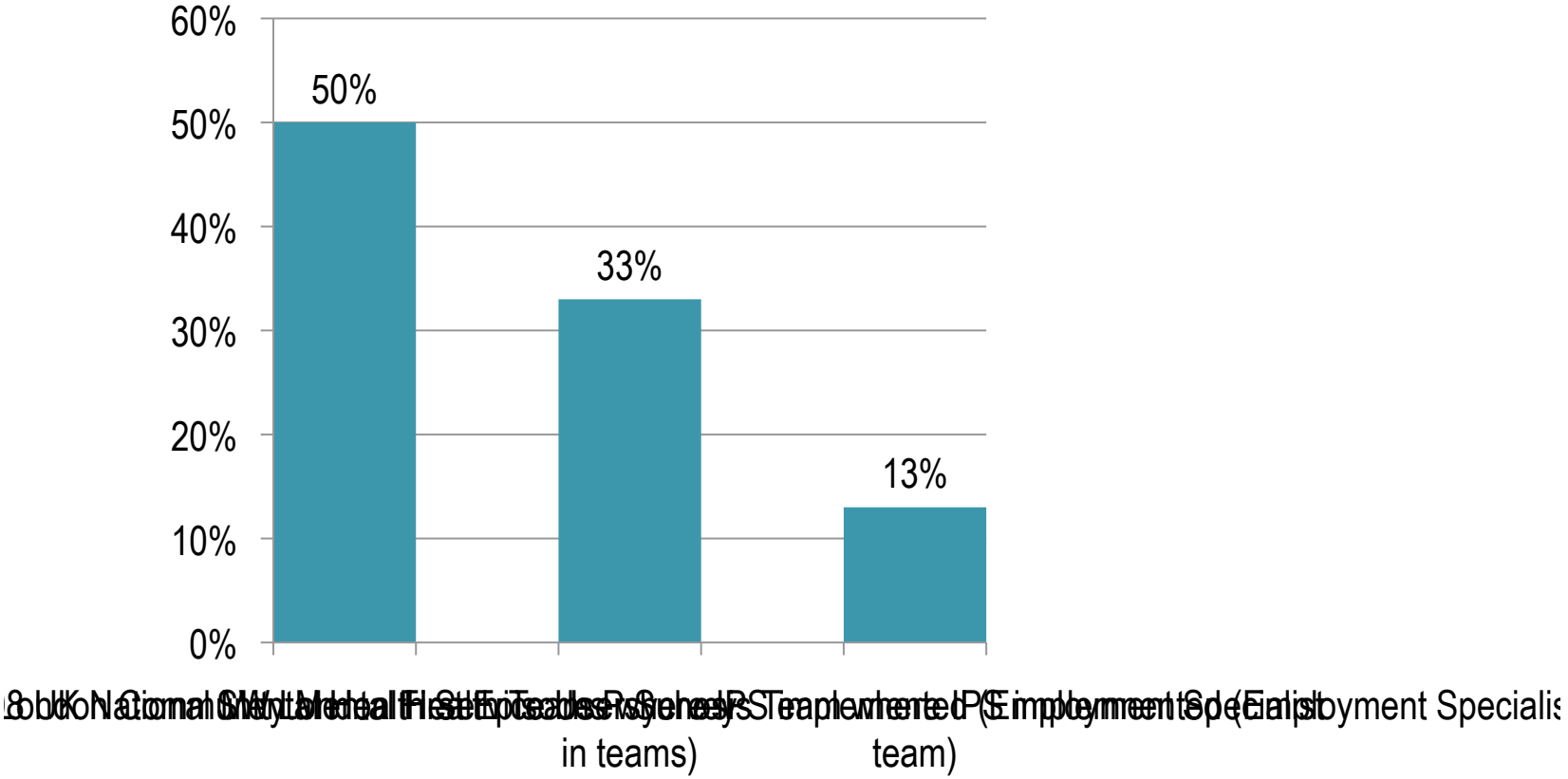
IT Helpdesk
Admin Assistant
Civil servant - executive officer
Baker x2
Carpenter
Caretaker
Hairdresser
Sales Assistant x8
IT Support desk
Administrator
Decorator
Cleaner
Street cleaner
Warehouse worker
Market research administrator
Care assistant

Civil Servant (administrator)
Production assistant
Assistant special needs teacher
Administrative assistant x5
Regeneration project worker
Glazier
Plumber
Catering manager
IT trainer
Nurse
Health records officer

Hairdresser assistant
Indian Restaurant waiter
Leisure assistant
Driver
Bar work
Barista
Sales Advisor
Boatyard worker
Café Assistant
Catering assistant
Teaching assistant
Social worker
Youth Worker
Financial controller

By providing support we increase people's belief that they can work

Proportion of people who had 'written themselves off' as unable to work because of their mental health condition



Within the IPS principles types of support/ adjustments we have found helpful

- **Peer support** - individual mentoring, job clubs, support groups for employees with mental health conditions, individual 'journey to work' stories to provide hope and inspiration to others
- **Starting work gradually and building up hours over time**
- **Starting small and building up** - most people start their working lives in 'marginal' jobs ... but then move on in their careers – starter posts in 'marginal' labour force
- **Not just jobs, but careers ... and this does not always mean staying in the same job** - changing working patterns where people change jobs regularly
- **Not just '9 to 5'** - many ways of working ... including self-employment
- **Adjustments in the recruitment process** - working interviews, having someone there with you, more informal interview procedure

"I did attend several interviews but my anxiety was so debilitating that I never performed well""

- **Help to negotiate adjustments at work** – continuous or only when condition fluctuates

- **Help to think about disclosure: to tell or not to tell?** It is up to the individual when and who they tell about their mental health problems – there is no right answer - but it is helpful to talk through the pros and cons of different courses of action

- **Managing symptoms and problems in a work context: 'work health and well-being plans'** - these plans

  – increase confidence of employee and employer

  – offer a way of managing a fluctuating condition at work and planning fluctuating adjustments and supports

  – may be useful for all employees

"Having your own plan about how to cope and what you need is good for employer and employee."

A work health and well-being plan

“

- **Keeping on an even keel at work**
  - Things that are important to me outside work (and when I will do them)
  - Things I need to do every day/week to keep on an even keel
  - Things that my manager can do to help (adjustments and support)
- **A work health and well-being ‘first aid kit’**
  - Things I can do at work if I feel upset, discouraged, hopeless, angry, stressed out
  - Things I can do after work so I don’t take the troubles of the day home with met
- **Managing things that get to me at work**
  - Things that happen at work that make me feel angry, hurt, upset, stressed out
  - Things I can do when they happen to stop them getting to me too much
  - Things my manager can do to help

- **Plan for what to do if I am having an 'off day' – when I am not feeling 100%**
  - How I know when I am having am 'off day' – tell-tale thoughts, feelings and behaviour
  - What I can do to cope and get back on top of things
  - What my manager can do to help
- **Plans for what to do when everything is getting too much – when a crisis is looming**
  - How can I tell when everything is getting too much for me – when a crisis is looming – tell-tale thoughts, feelings and behaviour
  - What I can do to stop things getting worse – stop me messing things up
  - What my manager can do to help
- **Plans for returning to work after a crisis**

See for example Perkins, 2010 *'Surviving and Thriving at Work: A Work Health and Well-being toolkit* and *Going Back to Work After a Period of Absence*

contact **sarah.cosby@disabilityrightsuk.org**

- **Time limited 'work experience' or 'internships'** in parallel with job search and in real employment settings

An intensive Work Experience Programme in conjunction with IPS in SW London

- Furnishes people with references and an employment record for those who have never worked or who have not worked for a long period AND are anxious about trying employment
- Increases confidence of individuals and staff Allows sceptical staff to see that people can work
- Comprises 10 weeks work experience alongside job search
  - Work experience in real workplace
  - Individual and group help with job search and completion of application forms/ CVs with work experience
  - Help with preparing for interview and starting work – on-going support within IPS or user employment programmes

Between 2001 and 2009

- **142 people started the programme - 115 completed it (81%)**
- **49% entered competitive employment**
  - 8% entered mainstream education/training
  - 16% entered voluntary work
  - 27% remained unemployed and inactive
- **In comparison with those who went directly into employment**
  - Likely to have been out of work for longer (mean duration of employment 4yrs vs 2yrs) or never worked
  - More likely to have a diagnosis of schizophrenia (46% vs 28%)

But

- Work Experience is not a substitute for paid employment:
- Work experience is not a necessary route to employment

Not just ‘them out there’:

employing people with mental health problems in mental health services

Not just ‘them out there’ – employing people with mental health problems in mental health services

Why employ people with mental health problems in mental health services?

- **Provides much needed employment opportunities**
- **Health services are a major employer and treatment is not the only thing we can offer to improve health and well being**: we can also provide much needed employment opportunities
- **Expertise of ‘lived experience’ is important in promoting recovery**: people who have successfully lived with mental health conditions have expertise that is valuable in helping others who face similar challenges
- **Offers images of possibility:** challenges myths and stereotypes and counteracts despair and pessimism in both staff and service users, demonstrates that employment is a real possibility
- **Breaks down destructive ‘them and us’ divide**
- **Leading by example**: how can we ask other employers to recruit people with mental health conditions if we don’t put our own house in order?

A Supported Employment Programme
Established in 1994

Designed to increase access to employment in mental health services for people who have themselves experienced mental health problems – employment in ordinary existing positions on the same terms and conditions as everyone else

The context:

- No disability equality legislation
- NHS 'two year rule': guidance that people with mental health conditions should not be employed in health services within 2 years of having received treatment for a mental health problem

Two key elements

- A Supported Employment Programme (established 1995)
- A Charter for the Employment of People with Mental Health Problems (established 1997)
- Creating new 'peer workers' positions

The Supported Employment Programme Outcomes 1995 - 2010

People with mental health conditions employed in 257 jobs within the South West London mental Health Services

- 44% psychosis (28% schizophrenia, 16% bipolar disorder), 41% depression
- 80% at least one psychiatric admission
- Mean duration of unemployment = 2.4 years (max 17 years)
- 66% clinical, 27% administrative, 7% support services
- 84% continue in employment or further training

“It gives users an opportunity to get recognised as human beings.”

“I will always have severe and enduring mental health problems, but this is no longer my life. I am a mental health professional … The passion I have for my career is immense … This is what I am, and this is what I do. I am no longer a mental health condition.”

“When I was in hospital I thought my life was over until I met a member of staff who had mental health problems and told me about the User Employment Programme … without the support and encouragement I have received I wouldn’t be here … I am a happy person doing a job that I enjoy working with people experiencing the same things that I have … however, today I can show them that there is light at the end of the tunnel.”

But …

The supported employment programme suggests that people with mental health problems always need support in employment

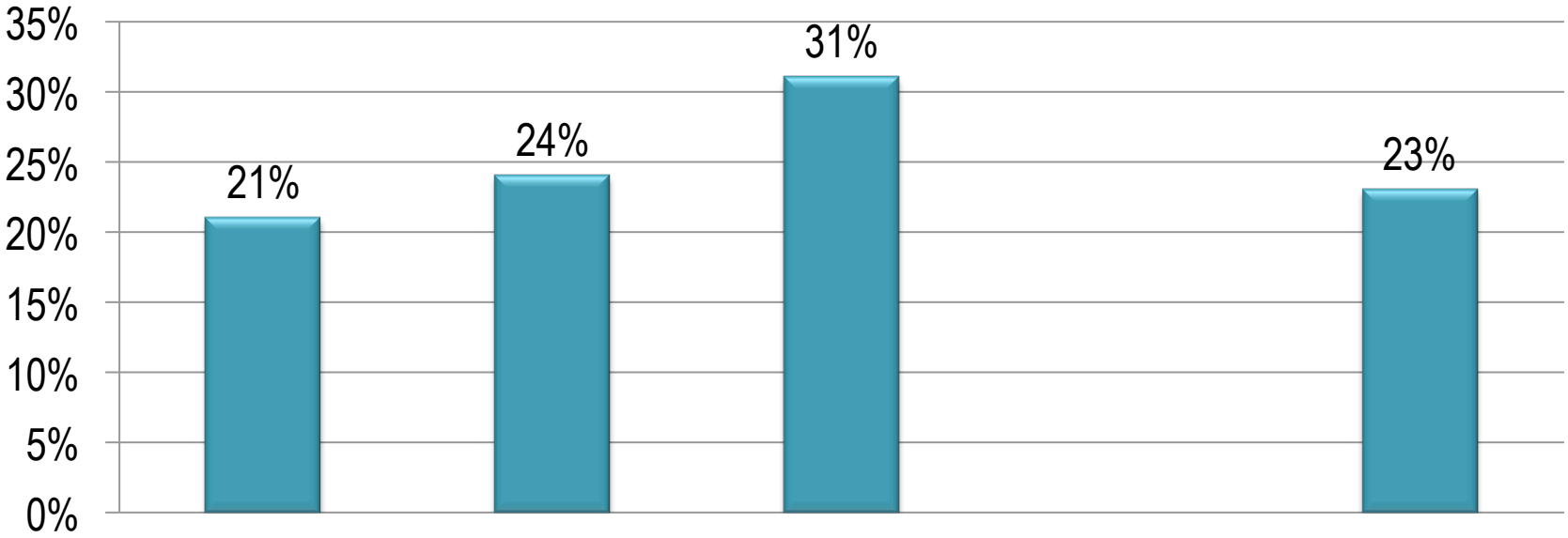
- For many the only barrier to employment is employers' reluctance to take them on
- Many can obtain the support they need from friends and services outside the workplace

A Charter for the Employment of People who have Experienced Mental Health Problems

- Designed to decrease employment discrimination against people who have experienced mental health problems throughout the organisation
  - Personal experience of mental health/addiction problems ‘desirable’ on person specifications for all posts
  - Advertisements encourage people with mental health problems to apply
  - Confidential equal opportunities monitoring includes mental health problems

- **Every year since 1999 at least 15% of recruits have personal experience of mental health problems**
- **Ten years after the charter was adopted 23% of recruits had mental health problems** (19% of applicants and 21% of people shortlisted had lived experience of mental health problems)

And the higher up you go the more of them you find ...



Bands 1-4
Lowest grades - support staff

Bands 5-7
Qualified health professionals
Team/service managers

Bands 8-9
Heads of profession
Senior managers

Includes:
Chief Executive
Consultant Psychiatrists
Director of Nursing
Senior nurses
etc.

But a Charter is not a substitute for active supported employment – in those UK organisations that simply developed a Charter very few people gained employment

Two ways of including the expertise of 'lived experience' in the mental health workforce

1. Employing people with mental health problems in existing positions in the workforce

2. Creating new roles and relationships - employing 'Peer Workers'

A nurse (or a psychologist, or a social worker or a doctor, or an occupational therapist) with mental health problems is still a nurse (or a psychologist, or a social worker or a doctor, or an occupational therapist)

They are employed as professionals and their relationship with the people who use services is that of a professional

Traditional power, hierarchy, claims to special knowledge about others etc. remain

There is increasing evidence that a different kind of relationship - peer support - is central to recovery – relationships …

Creating new roles and relationships - employing 'Peer Workers'

Peer support requires moving beyond traditional expert/patient roles

Creating new roles and relationships where people can learn and grow as equals drawing on each other's expertise and experience

Relationships founded on mutuality: shared responsibility, shared journey, reciprocity ... with people who are a few steps on in a similar journey

Employing people whose core expertise is lived experience (trained, supervised, a core part of the workforce)

Different sorts of peer worker roles, for example

- **Peer support workers/specialists in clinical teams**
  - important in fostering the recovery of those who they serve and changing culture of team BUT
  - mainly in lower ‘unqualified’ grades therefore expertise not seen as equal to that of traditional professionals
- **Peer trainers**
  - co-producing and co-delivering training in Recovery Colleges/ Education Centres for people using services and mental health workers
  - fundamentally changes power relationships – moving above unqualified grades
- **Peer researchers**
  - Evaluating effectiveness of services in peer terms

Not either/or both: Employing people in existing positions and creating new peer positions

We need to create new positions which are founded on the expertise of lived experience and a different kind of relationship (Peer Support Workers, Peer Trainers, Peer Researchers …)

BUT

There is a risk that we maintain destructive 'them' and 'us' boundaries' – some jobs for the 'mad' some for the 'sane' unless we also unless we also

- Value the expertise of lived experience in people in traditional professional and managerial positions
- Increase access to existing positions/professions for those who have lived experience of mental health challenges

Reinventing a very old wheel?

In late 1700's France at Bicêtre Hospital, the superintendent Jean-Baptiste Pussin (who himself had spent time in the asylum), instituted a policy of seeking staff from among 'recovered and convalescing' patients

The physician, Philippe Pinel said that because of their own experiences such people are better placed to understand and respond sensitively to the problems of patients

"They are the ones who are most likely to refrain from all inhumane treatment …"

The Challenges

The challenge of working with a mental health condition

- ***Affect a person's ability to negotiate the social world of work*** (rather than the physical one) – therefore need to think about adjustments/supports to access the social world of work
- ***Often fluctuate*** and it is difficult to know when fluctuations will occur – therefore need fluctuating adjustments and support
- ***Are not immediately obvious and engender fear*** because of the myths that surround them (dangerousness, incompetence etc.) – therefore need to break down myths
- ***Types of adjustment and support people may need less well explored*** – therefore need to provide more support to individuals and employers to think about what sort of adjustments and support are needed

But the biggest barriers lie not within the individual but in the attitudes of others and the type of support that is provided

Five inter-related problems

1. A culture of low expectations
2. Fear on the part of health professionals, individuals and employers
3. Failure to provide the sort of support we know works
4. Failure to implement it properly
5. Lack of joined up working at national and local level

1. A culture of low expectations

on the part of health professionals, employers, employment support agencies and people with mental health conditions themselves

Nicola Oliver (2011) a woman with bipolar disorder

*"**My first obstacle was my employer.** Ten days after I disclosed my disability I was sacked."*

*"**My second obstacle was my community psychiatric nurse.** He was lovely but recommended I consider only low stress jobs and part time hours; maybe I could stack shelves in a supermarket! I hadn't studied for three degrees to stack shelves."*

*"**My third obstacle was my psychiatrist.** She told me that it was unlikely that I would ever work again."*

Is it any wonder that with these messages from the 'experts ...

*"**My fourth obstacle became my-self.** I became 'Nicola the bipolar person': incompetent, inadequate and worthless."*

*"I was offered cognitive behavioural therapy to overcome my low self-esteem, but **the psychologist became my fifth obstacle.** She was adamant that I should stop yearning to return to work."*

But Nicola was determined – despite all the negative messages she continued to try to get work ... but employment support agencies were no better

*"**I contacted a recruitment agent who told me I had a great CV ... but she quickly became my sixth obstacle.** When I explained the gap on my CV was due to bipolar disorder I never heard from her again."*

*"**The seventh obstacle was the charity I approached to help me get into work** ... I was told 'maybe we should wait until you are a bit better'. You don't have to be completely symptom free to return to work. Research has proven that working expedites recovery from mental health symptoms."*

*"**My final obstacle was a disability employment advisor** who was supposed to help me find work. She wanted to send me on a confidence building course! I didn't want training, I wanted a job."*

"If only ...

someone had helped me reassure my employer I was still worth employing."

they had shown conviction that I could still achieve"

I had met other employees with bipolar disorder to inspire me to believe that one day I too could return to work."

2. Fear

on the part of health professionals, employers, employment support agencies and people with mental health conditions themselves

- **Employees with mental health conditions, and the mental health professionals who support them, see leaving benefits and entering the workforce as a risky business:**
  - Fear that working may make symptoms worse, that people will experience anticipated prejudice and discrimination, moving off benefits may threaten financial security
  - Uncertainty because of fluctuating condition – whether they can manage to work if condition worsens, whether former benefits will be reinstated quickly if it doesn't work out
- **Employers see employing people with a mental health condition as a risky business:**
  - Fear because of lack of understanding of mental health conditions and myths that surround them, that they will not be up to the job, that they will be disruptive in the workplace
  - Uncertainty because of fluctuating condition and lack of understanding of appropriate support and adjustments

... and in relation to employing people with mental health problems in mental health services

Some of the objections raised by mental health professionals

- ‘They won’t be able to cope with the stress of the job.’
- ‘They won’t have the skills necessary for the job.’
- ‘What happens have a crisis at work?’
- ‘What about transference - will they really be objective?’
- ‘Won’t they be dangerous to the vulnerable people we serve?’
- ‘Won’t they be unreliable - off sick all the time?’
- ‘Mentally ill people will be taking our jobs.’
- ‘We won’t be able to tell jokes in staff team meetings any more.’

3. Failure to provide the sort of support we know works

At an individual level …

- **Ignorance of research evidence**
- **Disbelieving research evidence – 'Yes, but ...'**

  'Yes, people with mental health conditions can work BUT 'my' clients are different ...'

  'Yes, it may work elsewhere (in the USA, in London ...) BUT it is different here ...'

At a systems level ...

- **People with mental health problems not seen as a priority for employment service programmes**
- **In challenging economic times we cannot afford it** – better to focus on those who are easier to help
- **Employment not seen as a priority for mental health services**
- **Investment (personal and financial) in existing ways of doing things** on the part of service providers, people who use mental health services and politicians (especially the closure of sheltered work places)

IPS evidence based supported employment challenges traditional assumptions

that are commonly held among individuals, professionals, employers and the 'general public':

- **Common assumption:** people need to be fully 'better' before they can return to work
- **The reality:** The longer they are out of work the less likely they are to return (without special support). In the UK:
  - 6 months absence – 50% return
  - 12 months absence – 25% return
  - 2 years absence – 2% return

  (British Society of Rehabilitation Medicine)

Treatment and employment support need to be provided concurrently from the start if people are to have the best chance of retaining their employment or returning to work as soon as possible

Common assumption: ‘stepping stones’: people need to build up their qualifications , skills and confidence in a safe, sheltered setting they will be able to move on to open employment

The reality: people learn that they can only work in a safe, sheltered setting and never move into work

People need ‘water wings’ – support to keep them afloat in employment - rather than ‘stepping stones’!

4. Failure to implement it properly

Many existing services say

‘we are already doing most of those things’

BUT with IPS the higher the fidelity to the model the better the outcomes – it is important to ensure that all 7 principles are met

- **Is employment really considered as a core part of assessment and support planning for everyone from the start?**
- **Are we really helping everyone who thinks they might want to work or are we still (implicitly or explicitly) ‘selecting’ people on the basis of our judgements about their ‘work readiness’ or ‘employability’?**
- **Do we really have a ‘can do’ attitude ... or** do we continue to ’write some people off’?
- **How good are we at job-finding and working with employers?**
- **How good is the advice and information we offer about benefits?**
- **Are we really able to offer long term support?** In the UK most people do not receive long term support from secondary services – once symptoms have been stabilised long-term support is often provided in primary care.

5. Lack of joined up working at national and local level

If people with mental health conditions are to receive the support they need to access and prosper in employment then joined up working is required across:

- mental health (primary care and secondary, specialist)
- social care services
- generic welfare to work programmes
- welfare benefits systems

Unless we do this we will have

- Confused and contradictory policies and approaches that are wasteful of resources
- Confused customers and clients who are receiving contradictory messages

A changing environment ...

An increased attention to mental health and employment

Increased concern about the HEALTH, PERSONAL and SOCIAL costs of unemployment and the right to work

AND

Increased concern about the ECONOMIC costs of welfare and the rising number of people with mental health conditions receiving out of work benefits

"An unholy alliance between therapeutic radicals and fiscal conservatives"

- **In the UK:**
  - employment outcomes central to new mental health strategy
  - increased attention to people with mental health conditions in generic and disability specific employment programmes
- **Internationally:**
  - OECD programme looking at mental health and employment

It may not be easy but it really is worth it!

"I have re-entered full-time employment. Over a year later I am still working. I now focus more on opportunities in life and less on my condition. I regularly socialise with my colleagues after work and actually feel content to be a taxpayer again … The support has been immeasurably important …[it] *has enabled me to make the journey towards recovery and realise my aim of contributing to society again through fulfilling employment."*

"My passion for my career is immense. A job defines you, provides money, personal fulfilment and a sense of achievement. This is what I am, this is what I do, I am no longer a mental health condition."

"Now I'm a contributing member of society because of my employment. It's worth is altering the life of someone with a mental illness … helping me to change direction from hopelessness to being worthwhile."

What sort of challenges do you see in implementing IPS in your own services?

How might you overcome these?

What sort of challenges do you see in employing people with lived experience of mental health conditions in your own service?

How might you overcome these?