Chapter 8

Putting the community back into community care

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Introduction

People employed within community mental health services have chosen a career that is immensely challenging and potentially rewarding and enriching. Their work to support people in moving from crisis and despair towards a renewed sense of strength, independence and well-being should be creative and fulfilling.

Yet research suggests these ambitions may be pursued at a personal cost and with unsatisfactory results. Community mental health professionals, particularly social workers and community psychiatric nurses (CPNs), often experience low morale, emotional exhaustion and 'burnout'.[1] Where morale is low, outcomes for people using services may be adversely affected.[2] Few people attending community teams take up paid employment[3] or get help to tackle the discrimination and stigma which may have a more damaging and long-term disabling impact than their ill health. In fact, many people who use mental health services feel the services are themselves discriminatory, failing to listen to or respect their aspirations.[4] It is argued that people get little help to be 'socially included' within their neighbourhood despite receiving community-based services.[5]

Instead of helping people to get out of their rooms and into college or voluntary and paid work, instead of helping them to use local leisure facilities and make new friends, community team staff report a preoccupation with risk assessment.[2] Staff may not want to work in this way but they face many pressures which combine to cause a focus on personal and public safety. They may have limited encouragement or time to help people move out of their 'comfort zone' and take the risk of a new and interesting but daunting venture in the local community. High caseloads may be partly – but by no means entirely – responsible for reinforcing this risk-averse approach, which is determined by the *use* as well as the *amount* of time available.

The good news is that there are increasing numbers of people at all levels of mental health services who are changing the focus of their work. They are breaking down the physical and psychological separation of the community team from the variety, potential and wealth of their local area. Many are driving forward a new vision of their purpose, by seeking ways of validating the 'community' aspect to mental health services, building partnerships, changing attitudes, gaining new skills and more flexible ways of working. This chapter draws on our study of three NHS trusts[6] that are seeking these kinds of changes

in relation to employment, on our experience of supporting those attempting to find new ways of working and on the work of other writers and researchers, to look at some of the concerns and achievements of community-based mental health staff, their service users and senior managers. Evidence from our study and from other research suggests that a new way of working may not reduce staff workload but can make a powerful and beneficial impact on both service users and their professional support staff, as they find a renewed sense of purpose and achievement. In the following sections we describe the three sites that took part in our study and discuss their experiences in relation to six issues:

- the challenge of developing a new vision
- introducing and working with vocational expertise
- communication, respect and trust
- influence and guidance
- tapping into community resources
- finding allies in black and minority ethnic community groups.

The study sites

The three study sites, described here as sites A, B and C, were chosen to facilitate exploration of different approaches to increasing service users' access to vocational expertise. Site A had recently completed a 12-month pilot project involving the appointment of a vocational specialist to work with two community mental health teams (CMHTs), in line with the Individual Placement and Support (IPS) approach. Site B had a vocational specialist based within an industrial therapy unit. His responsibilities included providing a vocational support service to all community team and day service clients. Site C had developed a model of vocational support that involved allocating a vocational lead role to an occupational therapist (OT) within each CMHT. The OTs were supported and advised by a vocational specialist responsible for the whole locality and employed by the trust.

Since the aim was to explore participants' experiences, qualitative data collection methods were used. These comprised semi-structured interviews with team staff who held care coordinator responsibilities, the vocational specialists and other professionals identified by local staff as important resources in providing employment support to clients.

The challenge of developing a new vision

Our study found that in all three sites some managers, staff and service users were calling for community mental health services to instil hope in those who use their services and to take their need for a decent home, friends and a valued occupation at least as seriously as diagnosis and medication. This is now becoming a familiar theme in mental health[7] reinforced by the recent Social Exclusion Unit report.[8] However, even where there is commitment at a senior level, changes in focus and ways of working are hard to implement. Many professionals have been trained in and grown accustomed to a more medical approach

and their attitudes may be hard to shift. Consequently, the new rhetoric sometimes turns out to be just another way of doing things within the same institutional framework.

For instance, some trusts are looking to 'social firms' to provide work opportunities for their service users. Businesses accurately described as social firms can make a useful contribution where they are part of a spectrum of employment opportunities. However, the term is sometimes used to describe work activities identified as the safe and therefore preferred option for people using day services and these then start to look like a new form of sheltered employment.[9] Similarly, voluntary work can be an important element in a spectrum of opportunities but if voluntary work placements are developed within the mental health trust for an indefinite period with no planned or supported route into paid employment, this confines mental health service users to unemployment and potential exploitation. Even paid employment for a few service users within a trust may be progress but does not indicate a fundamental change of vision or direction, unless accompanied by new support systems and major changes in the practices of occupational health and human resources departments, and team managers.

> A lot of the good work that's happened here has been very insular and doesn't fit into the wider community, if anything, it's quite institutional, it's a new type of institutional thinking... it's not actually about people having roles in the community you know, or having jobs out there in the wide world. (Senior manager, site B)

A further force for resistance to the new agenda is the UK government's focus on public protection, fuelled by a small number of tragic incidents that have generated adverse publicity. This adds to the complexity of the challenge facing mental health services but should not lead to oppressive services for the vast majority of people with mental health problems. Risk assessments can be used to determine what a person *can* do and what risks they *can* take, just as powerfully as indicating what risks should be avoided. The need to avoid risk can be used to argue for improved, integrated support services, to ensure that people can access the help they need as they move forward in their lives. Failure to provide this integrated approach can result in people either not moving forward at all or taking on a job without easy access to help when they need it. As Jenny Secker and colleagues illustrate in Chapter 7, the consequence may be job loss and ill health, through no fault of individual support staff but through a failure to work together on employment issues.

Despite concern for public protection, the call for mainstream mental health services to actively support social inclusion remains loud and clear. The government recognises the reduced risk of self-harm for those in employment and requires mental health services to take this into account when shaping their services.[10] There is also a range of policy documents promoting social inclusion.[8,11] Citizenship is becoming a familiar word in a mental health context. Civil rights are being asserted: the right to work, to respect, to choice and to freedom from discrimination.[12] It is argued that the mental health world needs to move on into a 'new phase of development'.[13]

Introducing and working with vocational expertise

A key element of the new vision is enabling people to obtain paid employment in ordinary jobs. This requires introducing vocational expertise, both from specialist staff but also to some extent within the core skills of CPNs, social workers, psychologists and psychiatrists. They all have an important role to play in helping their service users achieve sustainable, rewarding and enjoyable employment (as we all hope to achieve). Financial investment by the NHS (new or reallocated) is required to bring in the vocational expert but it costs nothing to set a clear mandate for all mental health staff to jointly contribute to employment support.

In our study of three sites, we found community mental health staff varied in their response to the notion of sharing the task of providing vocational support. A small number of staff (of all disciplines) entered wholeheartedly into this, seeing it as central to their role but some passed over all responsibility to the 'vocational expert' and did not perceive vocational issues to be relevant to their own job. Others felt that they themselves had the necessary expertise, although there was little evidence to support this view. At site C, where the teams participating in the study had allocated a specialist vocational role to their occupational therapists, the care coordinators and key workers played little part in vocational support, despite the rhetoric of partnership working. At site B, the vocational specialist was located in a different building. Although the clinicians expressed a wish to work with him for the benefit of service users, the vocational expert did not appreciate the value of a joint approach, taking a stance similar to the clinical recovery model described in the previous chapter.

> We're more interested in the person's future so we don't phone the key worker for any sort of assessment or past medical history or anything like that. (Vocational specialist, site B)

Unfortunately, staff and vocational specialists who felt no need to work together effectively denied service users access to specialist information and support. At site A, on the other hand, the IPS philosophy was embedded in the attitude and practice of the vocational expert and senior management and was supported by the psychiatrist and it was at this site that working relations between clinicians and vocational experts were found to be closest. Even clinicians who were initially sceptical came to believe in the value of joint working as the service developed. Not only did it improve the lives of their service users but it also lightened the pressure upon the staff themselves who gained satisfaction from improved outcomes.

As a result, at site A the staff felt able to help any person who was motivated to try for an ordinary job in the locality. No one who wanted to get an ordinary job was excluded and this gave satisfaction to both staff and service users.

> She's one of the most difficult people we have on our whole caseload in the team and to find something... was quite difficult... it took a lot of time, a lot of effort, and a lot of work... but it was worth it. (CPN, site A)

Communication, respect and trust

The primary factor in developing good interprofessional working identified in our study was the shared vision of an integrated service. At site A, just such a vision provided a clear lead right through from the chief executive, senior managers and psychiatrists to the team leaders, influencing how staff understood their role and spent their time.

> She [the team manager] was a CPN. . . just had a passionate belief about people in the service having opportunities. . .I think knowing that was valued by her was a good influence on the team. (OT, site A)

This commitment to a positive, integrated approach to vocational issues has to be shared by the vocational expert. Instead of taking the independent approach described above, the vocational worker will only win respect and cooperation if he or she, in turn, respects and values the contribution of clinical staff.

> You can't do the vocational without the clinical. . . I have a respect for the clinician's expertise and their background knowledge of the client. . . the key worker's crucial. (Vocational specialist, site A)

Our research concluded that this consistent lead and vision, backed up by structural change and new financial priorities, is essential if we want to guarantee a different experience for service users. Implementing the vision, once the structural and financial changes are made, requires easy, frequent, formal and informal communication.

> It's constant communication and collaboration, with the client, key worker, myself all in agreement. (Vocational specialist, site A)

Communication helps to build the trust necessary for good collaboration. Mental health professionals will not want to refer their service users to others unless assured of their competence. Vocational activity can improve health and may engage those who are still experiencing symptoms of ill health and lacking in self-esteem. Their professional support staff will want to be assured that, if they make a referral to the vocational expert, the outcome is not likely to be harmful. In our three-site study, the necessary trust was established through frequent and easy communication with some staff quite quickly but with others, it took a period of time. Staff stability was therefore an important factor in success.

Location and office design were found to make a significant difference to easy communications. Much learning and trust grew during informal conversations over coffee, where staff of different disciplines, including the vocational expert, met for problem solving and sharing experiences. Team stability and investment in professional development enabled trusting relationships to become established. Where vocational expertise is lodged within an external agency or is geographically separate, this level of communication, respect and trust will be much harder, if not impossible, to establish.

Formal communications were also important, including invitations to Care Programme Approach (CPA) and other case reviews. An invitation to attend reviews acknowledges the contribution of the vocational expert and makes it possible to tap their knowledge of the service user when making important decisions about their future. Similarly, if clinical staff visit employment projects, this can help to increase trust in their work and raise expectations for their service users.

Stories of successful service users who have been supported by NHS colleagues make an impact, whether this communication is over coffee, in the trust newsletter or by presentations from the service users themselves. Staff will be interested to hear of the benefits not only to the service users but also to their professional colleagues, who may have been able to reduce the level of support as the service user regained confidence.

Data collected on the numbers of service users entering employment, education and voluntary work can, if analysed and reported back to individual teams, help staff to compare their ways of working and sends a positive message back to those who are doing well.

Staff with academic interests and psychiatrists in particular may come to value new ways of working by seeing research data on the benefits of employment and the harmful effects of unemployment. For others, communication with a range of workers with whom they work in partnership (employment, housing, leisure staff) can help to broaden understanding of 'what works' for mental health service users. The limitations of the medical model will become apparent as other ways of helping people to regain their well-being are understood.

Influence and guidance

Our study also found that clear guidance to clinical staff helped them to demystify vocational issues, which are unlikely to be covered during their professional training, leaving clinicians feeling disempowered and uncomfortable in this area of work. Torrey has provided practical information illustrating the kind of help clinical, social work and support staff can provide.[14]

- Helping service users and clinical teams have realistic vocational expectations.
- Coordinating service users' clinical and rehabilitation plans and interventions.
- Providing basic support and problem solving to service users.
- Contributing their insight to appropriate job matches that will support service users' health management as well as vocational needs.
- Helping service users manage their mental health problems.
- Helping families adjust to the service user's employment.
- Helping support service users' long-term rehabilitation efforts by keeping a positive frame of mind.

The overriding message from Torrey and others is that vocational support should not be seen as an additional task for clinical staff who already feel over-

burdened but as requiring simply a shift in the kinds of questions clinicians ask.

Perhaps the most important contribution that clinicians can offer (and the contribution often most valued) is positive encouragement, a 'can do' attitude that spreads self-confidence and a determination to succeed. As Bob Grove and Helen Membrey demonstrate in Chapter 1, motivation to get a job is a key factor in success for service users moving into work and clinical staff play a crucial role in developing this.

> They [clinicians] have this very positive influence, so very very crucial. (Vocational specialist, site A)

Case supervision and reviews can be used to remind clinical staff that work is achievable if the individual wants it. If the first steps into employment are not successful, then clinical staff and their service users can be reassured that setbacks are normal for all of us and do not imply that it was a mistake to try. The attitude of team managers and psychiatrists, backed up by trust policy and chief executives, is crucial to support staff in opening up opportunities where earlier they might have only seen risk.

> Dr A is actually the one who most values work, he will suggest work in places where I wouldn't have... that's good to discuss it and look at the potential. (Social worker, site A)

Caseloads must be at a manageable level and it has been suggested that 25 is the maximum where positive and creative support can take place.[15] Managers can encourage flexible working hours, with support meetings taking place near the workplace or college so that people can take up full-time employment *and* maintain their support, which they may perceive to be a lifeline.

Staff can be advised to keep open the files of people who begin to attend an employment support service, instead of closing the case soon after referral. The first weeks of transition into employment may involve intense work but in the long term, dependency on mental health services is likely to be reduced. However, as noted above, quick access to mental health support can be a crucial factor in job retention.

Staff training on vocational issues is likely to appear most inspirational and less threatening if it is delivered firstly by people who have used services, and who can describe the help they received, and secondly by colleagues of the same profession who champion employment support as central to their professional role. Each profession has a particular contribution to make. This might include finding the right medication to suit a person's lifestyle, working with their family, helping them to function effectively in the workplace or developing their social skills. The new way of working can be introduced as a way of enhancing professional skills and confidence.

A manager who appears to be making yet another demand on staff will not be welcomed. In view of the immense pressures of workload and responsibilities facing mental health professionals, it may be useful to emphasise the ways in which these can be managed more easily through sharing the burden and enjoying increased rewards.

Influence from colleagues can be more subtle than guidance or training and

at least as powerful. In particular, colleagues who have used mental health services bring a new perspective and give a new, positive image of what can be achieved. Increasing numbers of mental health trusts are recruiting people who have used mental health services to specified 'user' posts, with a mix of success as some professionals have initially found it difficult to trust and respect a former 'patient' as colleague.[16] People who have used services often have a deep commitment to helping others who come after them[17] but many have argued that it is best if specified user posts are replaced with an opportunity to compete on an equal basis with others for any job within the trust, with their particular expertise valued in the recruitment process. Disclosure of their health will then be a personal matter, as it would be for any other member of staff, and they have equal rights in this respect. Their values and experience will still influence other staff, perhaps in subtler, quieter ways.

An example of this is to be found on a ward in Sheffield, where one member of staff, also a service user, got permission to run weekly advice sessions on employment on his ward. Although his post was ward based, he got permission to take people out to sort out employment and training before discharge, to make hospital admission less harmful.[18]

The vision, communication, guidance and influence described above can give clinical staff all they need to work with their vocational experts and support their service users to achieve their ambitions. Their work becomes less focused on prevention of harm and more on the realisation of individual aspirations and is therefore immediately more creative and exciting.

Tapping into community resources

People who use community mental health services will need more than the expertise of their care coordinator and vocational worker to recover a rounded, fulfilling life. Community agencies and local people have a lot to offer but ill health and the discrimination that follows may leave people with mental health problems isolated and reluctant to make contact. Community mental health services, including both clinical staff and vocational experts, can tap into these local resources and help to break down the barriers.[19]

> The incorporation of evidence-based practice within vocational rehabilitation into the clinical teams has led to a shift from a purely medical outcome to a social outcome... the teams are now more socially connected with their communities.

An essential partner will be a source of benefits advice 'on tap' when people are moving into work, training or study. Our study in three sites found welfare rights advice problematic at all three and the widespread ignorance of clinicians about benefits issues was of particular concern. Some staff had an unfounded confidence in their own expertise. This created additional barriers to work and may have meant that individuals did not receive their full in-work entitlements. A partnership with an independent agency to provide immediate, expert advice may need to be supported by funding, due to the operational pressure experienced by most independent welfare rights agencies. The advantages of investing

in this for the trust will be the increased confidence and pace at which service users will move into vocational activities.

In addition to arrangements with an independent service, community mental health services can receive invaluable help from JobCentre Plus for their service users' welfare benefits and job search. The vocational expert serving the community mental health team will work very closely with JobCentre Plus but it is important that clinical staff also feel comfortable dealing with Jobcentre personal advisors, disability employment advisors and other staff to help support their service users into work. JobCentre Plus is trying to address the lack of trust and understanding between its advisors and people with mental health problems, partly through outreach services, and it may be possible to establish an outreach service at a comfortable location, maybe within a day service.

The neighbourhood and wider locality will have a wide range of employers, community groups, self-help groups, spiritual and religious centres and others that all have something to offer.[20]

> The reality is that community groups can and do want to help but we as professionals don't go and ask them. . .These are groups which see people in the streets acting strange, having arguments outside the bus stop, people who are unwell. They're not going to change their ideas unless we go and tell them we have a wealth of talent.

Many employment workers make the same point: ask employers and others to accept mental health service users within their organisation and often there is a positive response. As the study described in Chapter 7 illustrates, the discriminatory attitudes of employers can dissipate when someone speaks with authority and confidence about a job applicant's suitability for a vacant post and offers support when needed.

This can open up opportunities for a wide range of interesting work experience, leisure and social activities. People who have been unwell may be seeking a change of direction; young people may be uncertain of what their skills and aspirations are and may be motivated to try out new activities. The range of organisations which can offer these kinds of opportunities is enormous, from steam engine preservation groups to nature conservation organisations or the local CD shop and dance club.[21] It will help if mental health staff can work confidently with these, as and when necessary, although the lead role in developing partnerships may be taken by a vocational expert or non-clinical member of staff.

Home tutoring and specialist provision at college may be available in the local area or could be developed with support from community mental health services. The emphasis needs to be on enabling people to move on to mainstream provision at the earliest opportunity. Confidence increases as skills return and increase and the expense of such a service may be recouped through reduced medication, support and entry to employment.

Professionals may anticipate and fear rejection from people outside the field, reflecting their own assumption that service users are more likely to experience long-term disability than reveal a wealth of talent. Yet if these professionals instead had confidence in their service users' potential, they could instil

confidence in others who may have no information apart from often negative media coverage.

As people with mental health problems start to take up training and work, it is appropriate that they should begin to tap into alternative sources of support. The neighbourhood may be rich in opportunities for this, in the workplace or at college, with local community groups, interest groups, churches and other spiritual centres. Access to natural supports such as these can be fostered or facilitated alongside clinical support, so that in time friendships may develop and reduce the need for professional help.

Finding allies in black and minority ethnic community groups

Community agencies led by and serving people from black and minority ethnic groups can have immense value, if they have an acceptance and understanding of mental health issues. Once again, joint working is more helpful to the service user than a referral and case closure but the role of the mental health professional will need to be explored with the individual and his or her community agency.

It is well documented that statutory services have difficulty addressing the mental health needs of black and minority ethnic groups.[22] Fear, on the part of both professionals and service users alike, plays a part in this[23] but institutional and direct racism is found within the NHS as it is within our other institutions, exacerbating the problem of low expectations for people with a mental health diagnosis.

Specialist employment services for people with mental health problems often fail to attract proportionate numbers of black and Asian service users,[24, 25] but anecdotal evidence suggests that employment support is highly valued if it is offered in a format which is accessible and acceptable. As one staff member at a black voluntary organisation put it:

> He has been working on his CV. He wants to go into bus driving... I spoke to his social worker and he said 'It's unbelievable...No one has ever been able to engage with him'.

Integrated vocational and mental health support can be achieved and acceptable for this population. Key factors in success suggested by preliminary investigations indicate the importance of a location in the community, flexible ways of working, an encouraging, can-do attitude and partners who can offer expertise and opportunities free from discrimination. Peer support helps to restore hope which may have been crushed by education, health and employment services.[26] As a result of their experiences, some black service users may lack the self-esteem or social skills needed to cope with the multiple pressures of racism and mental health stigma.[23] Black-led services can help to restore a positive sense of identity and help people to develop ways of coping with day-to-day experiences in the workplace.

Employment services based within black and minority ethnic agencies fulfil a

useful function but, as with community teams, they need stability to establish effective partnerships and this requires secure funding. Moreover, potential partners such as colleges, JobCentre Plus and welfare rights agencies may themselves need training or resources before they have the language, skills or confidence to provide a service easily accessed by black clients. Funding arrangements can prove difficult as many black and minority ethnic agencies aim to support those in need (regardless of diagnosis) and to provide services not usually included in care planning. To achieve joint working with these agencies, mental health professionals, senior managers and commissioners need to look beyond the medical model of mental distress and open their minds to new ways of doing things.

At all levels within the NHS, there are psychiatrists and staff exploring ways of working that are more responsive to the needs of black and minority ethnic communities[27] but they remain at this time a minority force. However, there are mental health professionals, maybe many, who are aware of the need to improve provision for their black service users and who, given the opportunity, would welcome partners who can support them in this.

Conclusion

The fundamental shift required by mental health professionals is to find new ways of working with new colleagues and partners. This can appear daunting, even alarming, unless management and staff can agree on a clear and achievable goal. A defined purpose avoids the pressure of apparently incompatible demands which can burden mental health professionals.

Many service users are asking for services not to aim at stability, safety or maintenance at the expense of stimulation and personal fulfilment. The goal now sought by many people is 'recovery', not in the clinical sense with an endpoint of stability but in the social sense of finding a new way of living a fulfilled life in the community, managing their health problems and gaining sufficient control over their lives to enjoy the security of a decent home, a good job, a circle of friends and the opportunity to exercise civil rights.

If people want to live without a high intake of drugs which leaves them lethargic and their life grey, there may be no guarantee of freedom from symptoms of ill health. However, occasional periods of ill health become less damaging if services help people to maintain their job, home and social networks during these difficult times and enable them to return to normal activities as quickly as possible.

Once clinical staff are reassured that they will not be blamed for every hospital admission, they can enjoy encouraging their service users to try out new ventures and then share enjoyment of the increased confidence and well-being that are likely to follow. The workload may be the same but the rewards will be much greater. Staff working in this way, with a range of partners and connections in the local community, have a great 'toolbox' of resources, as well as a team which can share pressures, problem solving and setbacks.

The message from our study of the three sites taking on the challenges we have described is that where vocational and mental health support are integrated, the work can be both exhilarating and supportive.

> You're not just an isolated person, you're suddenly a force... I personally felt more empowered by that, and the more empowered I feel that has a knock-on effect for the clients. (Vocational specialist, site A)

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