MENTAL HEALTH ISSUES: GUIDE FOR ADVISERS

An education, training and employment guide for advisers

This guide was produced on behalf of advice-resources by the International Centre for Guidance Studies (iCeGS) in association with OLM-Pavilion.

(Last updated March 2009)
<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction (please read this section first)</td>
<td>1</td>
</tr>
<tr>
<td>1 Mental health problems</td>
<td>3</td>
</tr>
<tr>
<td>2 The relationship between learning, work and mental health</td>
<td>9</td>
</tr>
<tr>
<td>3 How mental health impacts on people’s access to and use of careers and advice services</td>
<td>14</td>
</tr>
<tr>
<td>4 The policy context</td>
<td>16</td>
</tr>
<tr>
<td>5 Working with clients who have mental health problems</td>
<td>22</td>
</tr>
<tr>
<td>6 Client groups with differing needs</td>
<td>30</td>
</tr>
<tr>
<td>7 Specialised support – including further signposting, contacts and referrals</td>
<td>33</td>
</tr>
<tr>
<td>8 Learning and working opportunities for adults with mental health problems</td>
<td>37</td>
</tr>
<tr>
<td>9 Welfare benefits</td>
<td>47</td>
</tr>
<tr>
<td>10 From the client’s point of view</td>
<td>50</td>
</tr>
<tr>
<td>11 Continuing professional development (CPD) in mental health issues for advisers</td>
<td>57</td>
</tr>
<tr>
<td>12 Glossary of terms and jargon buster</td>
<td>62</td>
</tr>
<tr>
<td>13 Further reading and information</td>
<td>65</td>
</tr>
<tr>
<td>14 References</td>
<td>67</td>
</tr>
<tr>
<td>15 Templates from this guide are available as separate documents in Microsoft Word</td>
<td></td>
</tr>
</tbody>
</table>
Introduction
Guide for advisers

Who is this guide for?
This guide is for those advising adults with mental health problems. Advisers will include nextstep advisers, Careers Advice Service career coaches, advice and guidance practitioners in higher and further education, Jobcentre Plus advisers and advisers working with adults in the broad information, careers and advice services, formerly information advice and guidance (IAG) services.

What does the guide cover?
This guide provides information, advice and ideas on topics related to education, training, volunteering and employment. It also touches on other issues that will have an impact on education, training and employment. Some topics, like marketing issues and mental health and links with employers, are covered in the companion guide Mental Health Issues: Guide for Managers, and advisers may wish to explore these if appropriate. Where it is not possible to provide information on a certain topic, we have signposted to other organisations or websites that should be able to help.

How should I use the guide?
The guide is divided into sections on different topics, such as ‘The policy context’. You can read the whole guide in full, or simply go to the section in which you are interested. There is some repetition so that each section can be read without too much cross-referral. If there is an acronym that you don’t know, you should find this in the glossary in section 12. Contact details for useful organisations, networks, other information sites and publications and staff development resources are also given in section 7 on ‘Specialised support’ and the ‘Further reading and information’ section of this guide.

The information in this guide
The content of the guide has been informed by many individuals and expert organisations. References used are to be found in section 14. The contents of this guide have been checked for accuracy. However, please note that some information is liable to change quickly – for instance, web addresses – and if you find an error, you should inform advice-resources at ca-advice-resources@lsc.gov.uk.

Who produced this guide?
This guide was produced on behalf of advice-resources by the International Centre for Guidance Studies in association with OLM-Pavilion. Many other organisations and individuals have made contributions to the guide: most particularly, Building Blocks Solutions Ltd. In addition to this guide for advisers, there are two separate but
complementary guides: one for adults with mental health problems, and the other for managers of information, advice and guidance services. These guides will be updated regularly.

**How can I give feedback?**
If you have comments about this guide for advisers please send them to ca-advice-resources@lsc.gov.uk.

(Last updated March 2009)
Mental health problems: background information

This section focuses on mental health problems: what the more common ones are, and how they may affect people. The term ‘mental health problem’ is used here as it is currently in wide use in the mental health field. It is important to point out that a variety of other terms are also frequently used: mental health difficulty, mental health issue, mental health condition, mental distress, mental disorder, mental illness, and mental ill health.

All human beings will have periods of stress and distress in their lives, often brought on by such things as loss or bereavement. What we are describing in this section are mental health problems and mental illnesses of a nature or degree that cause some disruption to a person’s life and lifestyle. In using the term ‘mental health problem’, it is very important to note that the term applies to a person’s mental state: the person him/herself should not be considered a problem.

Mental health problems are among the most common health conditions, directly affecting about a quarter of the population. One definition that may help is:

‘It is not easy to define “mental health difficulties” because the term encompasses a diversity of feelings, thoughts, behaviours and experiences. However, one way of looking at it is to consider mental health along a continuum, from serious mental ill health through to positive mental well-being. Most of us move back and forth along this continuum throughout our lives.’ (Taken from Learners with Mental Health Difficulties)

Mental health problems are common, the 2007 household survey showed that nearly one in four (23%) people in England experience at least one psychiatric disorder and those affected were more likely to have a lower household income.
Mental health problems are usually defined, classified and diagnosed by medical professionals: psychiatrists and general practitioners. However, some mental health diagnoses are controversial, and there is much concern that people are too often treated according to, or described by, their label. This can have a profoundly negative effect on their quality of life. For this reason, diagnostic labels should be used with caution. Nevertheless, psychiatric diagnoses remain the most usual way of dividing and classifying symptoms into groups.

In this guide mental health problems have been divided into three categories:
- common mental health problems
- severe mental illness
- other types of mental illness.

### Common mental health problems

#### Depression
The term ‘depression’ is used to describe a range of moods, from low spirits to more severe mood problems that interfere with everyday life. Symptoms may include a loss of interest and pleasure, excessive feelings of worthlessness and guilt, hopelessness, morbid and suicidal thoughts, and weight loss or weight gain. A depressive episode is diagnosed if at least two out of three core symptoms have been experienced for most of the day, nearly every day, or for at least two weeks. These core symptoms are:
- low mood
- fatigue or lack of energy
- lack of interest or enjoyment in life.

A depressive episode may be classed as mild, moderate or severe. This depends on the number and intensity of associated symptoms, such as sleep disturbance, appetite and weight change, anxiety, poor concentration, irritability and suicidal thoughts.

Between eight per cent and 12% of the UK population experience depression in any year.

#### Seasonal affective disorder
Seasonal affective disorder (SAD) is a form of depression that affects approximately 0.8% of the population at some point in their lives. There are two types of SAD: winter and summer depression.

#### Postnatal depression
Postnatal depression, also known as post-partum depression, is believed to affect between eight per cent and 15% of women. It is not the same as the ‘baby blues’, which are very common but last only a few days. Some women experience puerperal psychosis, and this is described below as a severe mental illness.

#### Anxiety
Anxiety is a normal response to threat or danger and part of the usual human experience, but it can become a mental health problem if the response is exaggerated, lasts more than three weeks, and interferes with daily life. Anxiety is characterised by worry and agitation, often accompanied by physical symptoms such as rapid breathing
and a fast heartbeat or hot and cold sweats. Stress is not considered a mental health problem in its own right, but long-term stress may be associated with anxiety or depression.

**Obsessive compulsive disorder**

Obsessive compulsive disorder (OCD) is a common form of anxiety characterised by obsessive thinking and compulsive behaviour. Obsessions are distressing, repetitive thoughts that may be seen as irrational but cannot be ignored. Compulsions are ritual actions that people feel compelled to repeat in order to relieve anxiety or to stop obsessive thoughts. For example, someone may believe that their hands are constantly dirty, so they wash them over and over again. Between two and three per cent of people will experience OCD during their lifetime.

**Phobias (including OCD)**

Phobias describe a group of disorders in which anxiety is experienced only, or predominantly, in certain well-defined situations that are not dangerous. As a result, these situations are avoided or endured with dread. The person’s concern may be focused on individual symptoms like palpitations or feeling faint, and these are often associated with secondary fears of dying, losing control, or ‘going mad’. Phobias are much more common in women than men, affecting about 22 in 1,000 women compared to 13 in 1,000 men in the UK. Agoraphobia is the term for a cluster of phobias that include fears of leaving home, entering shops, crowds and public places, or travelling alone in trains, buses or planes.

**Post-traumatic stress disorder**

Post-traumatic stress disorder (PTSD) develops following a stressful event or a situation of an exceptionally threatening or catastrophic nature. Intentional acts of violence are more likely than natural events or accidents to result in PTSD. Common symptoms may include re-experiencing the event in nightmares or flashbacks, avoiding things or places associated with the event, panic attacks, sleep disturbance, and poor concentration. Depression, emotional numbing, drug or alcohol misuse and anger are also common. The risk of developing PTSD after a traumatic event is 8.1% for men and 20.4% for women.

**Severe mental illness**

**Psychosis**

Psychosis describes a loss of touch with reality, which may include hearing voices, seeing something that no one else sees, holding unusual personal beliefs, experiencing changes in perception, or assigning personal meanings to everyday objects. Psychosis is associated with schizophrenia, schizoaffective disorder, puerperal psychosis, and severe depression, and is often experienced during the ‘highs’ of bipolar disorder. Other illnesses such as dementia can also feature psychotic symptoms. About one in every 200 adults experiences a ‘probable psychotic disorder’ in the course of a year.

**Bipolar disorder**

Bipolar disorder, also known as manic depression, is associated with severe mood changes that fluctuate from elation, over-activity and sometimes psychosis (together known as mania or hypomania) to a lowering of mood and decreased energy and activity (depression). It is diagnosed after at least two episodes in which a person’s mood and
activity levels are significantly disturbed, including, on some occasions, mania or hypomania and, on others, depression. A person usually recovers completely between episodes. Between 0.9% and 2.1% of the adult population experience a bipolar disorder at some point in their lives.

**Schizophrenia**
The diagnosis of schizophrenia refers to a group of symptoms: typically, the presence of hallucinations, delusions, disordered thought, and problems with feelings, behaviour, motivation and speech. When they occur together they represent a severe mental illness. Schizophrenia is the most common form of psychotic disorder, affecting between 1.1% and 2.4% of people at any one time.

**Schizoaffective disorder**
The diagnosis of schizoaffective disorder is given to someone who experiences both symptoms of a mood disorder (ie. depression) and symptoms of the type experienced with schizophrenia at the same time, or within days of each other.

**Puerperal psychosis**
Puerperal psychosis is rare, following between one and two in 1,000 births. The onset is abrupt, usually within days of the birth. The mother often starts to behave strangely, seeming puzzled and perplexed, sleeping poorly and being restless and erratic.

**Other types of mental illness**

**Eating disorders**
Symptoms of eating disorders include severely reduced eating, intense fear of weight gain, and self-perception that is overly influenced by weight or body shape. They also include significant levels of self-induced vomiting, laxative abuse and strenuous exercise for weight control. In any year, 1.9% of women and 0.2% of men in the UK experience anorexia. Anorexia is characterised by a failure to gain weight in relation to age, or excessive loss of weight, through avoiding food. Between 0.5% and one per cent of young women experience bulimia at any one time. Bulimia involves a preoccupation with food but is characterised by episodes of intense binge eating, preceded and followed by periods of starvation and/or self-induced vomiting and purging. About 40% of people referred to eating disorder clinics are classified as ‘eating disorder not otherwise specified’, with symptoms that don’t fit neatly into either the anorexia or bulimia classifications.

**Personality disorder**
This is a controversial diagnosis. Many people believe it is used in cases where symptoms do not obviously fit any other diagnosis. Personality disorder is used to diagnose a person who has difficulty coping with life and whose behaviour persistently causes distress to themselves or others. Personality disorders are characterised by long-lasting rigid patterns of thought and behaviour. The attitudes of people with a disorder usually exaggerate part of their personality and this results in behaviour at odds with expectations of what is regarded as normal. There are various types of personality disorder; one is ‘borderline personality disorder’, which is a diagnostic term applied to people who are perceived as both having a personality disorder and being on the border of psychosis. Between four and five per cent of people living in Britain meet the criteria of personality disorder in a clinically assessed way.
Dual diagnosis
There is considerable overlap between alcohol and drug misuse problems and other mental health problems. Where an individual experiences a mental illness and a substance misuse problem simultaneously, this is referred to as dual diagnosis.

Dementia
Dementia is a progressive and largely irreversible condition that involves widespread damage to mental functioning. Someone with dementia may experience memory loss, language impairment, disorientation, change in personality, difficulties with daily living, self-neglect, and behaviour that is out of character. Dementia affects five per cent of people over the age of 65, and 20% of people over 80. It is uncommon before the age of 65, but does affect one in 1,000 younger people in the UK.

Other important factors to consider

Suicide and self-harm
Suicide and self-harm are not themselves mental illnesses, but they usually result from mental distress. Suicide and self-harm are not necessarily linked with each other. The government (England and Wales) has set a target to reduce the suicide death rate by at least a fifth by the year 2010. Recent data have shown a decline in the UK suicide rate. In 2004, more than 5,500 people in the UK died by suicide. Deliberate self-harm ranges from destructive behaviours with no suicidal intent, which relieve tension or communicate distress, through to attempted suicide. The UK has one of the highest rates of self-harm in Europe, at 400 per 100,000 population. Types of self-harm can include cutting, burning and excessive drug and alcohol use.

Violence and mental health
There is a widespread public fear that people with mental illness pose a significant risk of violence to others, but research has shown that the degree of association between violence and mental illness is small and is accounted for by a small minority of people with severe mental illness. In fact, people with severe mental illness are more likely to be the victims of violence than the perpetrators.

Approaches in mental health work
Approaches in mental health work can be broadly categorised as:

• medical approaches – often referred to as ‘the medical model’; this is the dominant model and treatment will usually primarily take the form of medication
• psychological approaches – covering a wide array of different psychological therapies, often described broadly as psychotherapy or counselling or talking treatments
• social approaches – these seek primarily to address social factors, such as housing, employment, leisure activities, relationships and challenging discrimination
• recovery – this approach stresses the importance of hope and the need to challenge negativity and low expectations of the abilities of people with mental health problems; a recovery approach is rooted in the lived experience of
clients/service users; it is a strengths-based approach that reinforces the point that people with severe mental illness can and do recover.

Different approaches will suit different clients as they seek to make sense of their lives and the situation they find themselves in. A good mental health service will offer a variety of approaches, sometimes combining the approaches into a holistic package of care or support.

General things to bear in mind

- Everyone is different. No two people, including people with the same diagnosis, will be affected in exactly the same way. There is always the need for a personal, individualised approach.
- Although people will have problems and weaknesses, they will also have abilities and strengths.
- People with mental health problems will have good and bad days. It is important to check this out with them.
- Avoid using diagnostic categories to describe people – ‘She has a diagnosis of schizophrenia’ is a much more acceptable and accurate description than ‘She is a schizophrenic’.
- Psychiatry is an inexact science and the mental health field has many contested areas. This can be a bit confusing and confounding at times, but it is also stimulating, challenging and highly interesting.

(Thanks to the Mental Health Foundation, who gave permission for much of this section to be reproduced from their publication *The Fundamental Facts: The latest facts and figures on mental health.*)
The relationship between learning, work and mental health
Guide for advisers

‘People with depression, anxiety or severe mental illness are more likely to be unemployed or economically inactive than the wider population. Less than 25% of people with long-term mental illness have a job, compared to 75% of the general working age population. Motivation is not the problem: people with mental health problems want to work. In fact, they have the highest “want to work” rate of any disability group. Barriers to opportunities to work come from a benefits system that is inflexible, negative attitudes of employers and a widespread culture (including the NHS) that equates mental ill-health with hopelessness … unemployment due to depression and chronic anxiety costs the taxpayer £7 billion a year. In addition, overall productivity decreases when people do not work … the loss of output attributed to mental illness is estimated at £12 billion per year, or one per cent of total national income.’ (Bird, 2006)

This section is concerned with the overall context of mental health, learning and work, and in particular the impact of mental health on the individual and on society in general. It covers:

- learning, work and mental health, the context
- barriers to access to work and learning
- advice and support.

Learning, work and mental health, the context

Employment and positive mental health
The positive impact of learning and work on an individual's mental health is well understood. Research has shown that returning to learning as an adult and employment serve as sources of achievement and satisfaction, self-confidence, improved self-esteem and social activity and friendship. Learning and work also give structure and purpose to the day and, in the case of employment, can provide an identity and stated role in society. Employment is at the centre of most people’s lives. It follows that unemployment can have a detrimental effect on health and general well-being, and is associated with stress, low self-esteem and increased feelings of depression. Learning and work are, therefore, important factors in maintaining positive mental health and improving poor mental health.
Participation in employment and learning
People with mental health problems experience high unemployment, and those in employment who develop significant mental health problems often lose their jobs. While there have been significant increases in employment rates in the general population since 2000, including increases in employment rates for people with physical disabilities, there has been little increase in the number of people with long-term mental health problems participating in the labour market. In 2003, only 24% were in work in England – the lowest employment rate of any of the main groups of disabled people. People with severe mental health problems are especially vulnerable to unemployment: the unemployment rate for those with a diagnosis of schizophrenia is 95%. People with mental health problems who remain in employment tend to work in jobs with lower rates of pay and less responsibility than they had before their mental health problems started. In addition to relative exclusion from employment, people with mental health problems are under-represented in adult and further education. Once an individual becomes ‘excluded’ from learning and work, it can become progressively harder over time to be re-included.

Mental health problems are commonly experienced by people in work. Australian research in 2000 showed that nearly 11% of the full time workforce had suffered from a mental disorder in the last month. In the past month having a current mental disorder was associated with an average of one lost day from work and three days of reduced performance. The CBI estimated in 2005 that 6.8 working days are lost each year due to absence and of these, 36% are caused by stress, anxiety and depression. This equates to 2.5 days per person per year (quoted in the TUC Mental Health Awareness Course materials). The financial cost of mental illness to society is estimated to be between three and four per cent of GDP in EU states, costing the EU €436 in 2006.

One of the most positive models for support for people with mental health problems is the ability to work in a job that can be managed together with the mental health condition and the treatment. Part-time work or jobs that allow flexibility are good strategies if possible.

Attitudes of employers
A 2008 study shows that employers’ views are not generally negative toward employees with mental health problems. Employers who had no experience of knowingly recruiting an employee with a mental health problem were usually open to doing this in future. Most employers felt that no roles would necessarily be ruled out for such employees and positively, most employers recognised that the same mental health condition could have varying effects on different employees. A minority of employers in this study were hesitant about employing a person with a severe mental health problems and some employers had a zero tolerance policy on drug and alcohol use.

Double discrimination
Some people with mental health problems are even less likely to be employed, as a consequence of double discrimination in the labour market. This includes lone parents, who are three times less likely than average to be employed, older people, and people from ethnic minority groups. Another important and excluded group are offenders. Further information is given on these multi-discriminated against groups in section 6 of this guide. The difficulties faced by these groups are considerable.
Most people with mental health problems want to work
The low levels of employment statistics exist despite the fact that most people with mental health problems have previous employment histories and significant occupational skills and experiences and would like to be employed, or at least be engaged in some kind of meaningful work. This is equally true for those with severe mental health problems, who may be long-term users of support services and have therefore lost touch with the labour market.

Some clients may not want to talk about their mental health
Many people with more minor mental health problems do not ‘disclose’ or discuss their situations, so the complete picture of the impact of mental ill health on work and learning opportunities is unknown. Students in further and higher education, for instance, do not always inform admissions staff of their mental health problems, and many higher education students develop mental health problems in their first year as a result of stress and other factors.

Some career areas can contribute to poor mental health for some people
There is some evidence that some occupational areas contribute to poor mental health. A 2007 New Zealand study showed that one in 20 people can expect to experience depression or anxiety every year as a result of work. The most stressful jobs were found to be head chefs in large restaurants, schoolteachers, slaughterers, construction workers and top managers. The least stressful were postmen, librarians, hairdressers, legal and accounts administrators and speech therapists.

Barriers to access to work and learning
A number of barriers account for the low participation of people with mental health problems in the labour market. These barriers similarly affect people’s ability to learn, both formally in a college-type situation, and informally.

Stigma and discrimination
The Social Exclusion Unit report Mental Health and Social Exclusion indicated that stigma and the resulting discrimination form the greatest barrier to social inclusion for people with mental health problems. Over 80% of people responding to the consultation identified stigma as a key issue, and 55% described it as a barrier to employment. Discrimination can lead to relapses in mental health problems, and can intensify existing symptoms. A survey of personnel managers indicated that stigma is both realised and perceived: four in 10 employers would consider employing someone with a history of mental health, compared with more than six in 10 who would consider employing someone with a physical disability.

Loss of motivation and confidence
Mental health problems can have a negative impact on individuals; loss of confidence and selfEsteem is common. Lack of confidence can be a special barrier to undertaking learning: some people may assume that they will fail; they may not be able to ask for help, and may become very isolated in a learning situation. Even enrolling on a short education or training programme can be challenging for some. A consequence of loss of confidence and self-esteem is often fear of failure.
The relationship between learning, work and mental health

Isolation
For many people with mental health problems, loss of confidence leads to avoidance of new situations and of forming relationships. This can lead to a ‘vicious’ cycle of declining confidence, long-term dependence on welfare benefits, greater and greater alienation from the labour market and loss of social contacts.

Long-term disengagement from the labour market
Compounding all the other barriers faced by people with long-term mental health problems is a basic lack of knowledge of the world of work, what is expected of people in the workplace and how to access the jobs market if and when they are ready to do so. Some people do not have experience of work and others have been out of the labour market for decades, and for such people adding to the other barriers to work there may be a need to learn new skills, particularly new technology.

Effects of medication
The side effects of medication can exclude people from certain jobs, for example, because of drowsiness. Side effects can also interfere with performance at work. People with mental health problems feel that employers do not understand the issues about medication.

Drowsiness and lack of energy
These can affect people who experience depression and sleep disturbance, aside from medication side effects. People who are lethargic will find that their performance at work and in learning is greatly affected: commonly, they may have difficulty completing tasks, meeting deadlines and concentrating.

Concentration and memory difficulties
Many factors can contribute to these problems, for example, stress, obsessions and anxiety. People who experience memory problems, even in the short-term, will have difficulties in learning situations, whether in college, work or other situations. They may need to be supported and to find techniques to overcome these problems.

Low expectations of professionals
Health and social care staff sometimes advise against employment because of a lack of understanding about its benefits for people with mental health problems. According to the Social Exclusion Unit report, some advisers have poor awareness of mental health issues, and this can lead to a culture of low expectations, with the assumption that some individuals will never be able to work.

Fear of relapse
Concerns about fluctuating mental health and the possibility of falling ill at work prevent some people with mental health problems from seeking work. Others have attempted to stay in the labour market, but have had to accept a series of short-term jobs.

The benefits system
The welfare benefits system is widely considered to be a major barrier to employment, as many people feel that coming off benefits will put their financial security at risk. They have concerns about being worse off in work, and whether they will be able to reclaim their whole benefits package – which may have taken a considerable period of time to
secure in the first instance – if it does not work out. This will be explored further in section 9.

**Success factors for accessing work and learning**

Although no one size fits all, there are some identified factors that lead to success. Kathryn James, from NIACE, notes nine strategies that helped learners with mental health problems achieve:

1. having someone who encourages them and to whom the learner can go to for help if needed
2. being supported through learning opportunities that meet aspirations and goals
3. knowing that other people want the learner to succeed
4. support from family and friends
5. friendliness of tutors
6. own determination
7. being given information and advice on the right course for them
8. time to talk through options
9. support offered at the right time of life.

These factors are important in a general way with clients who are looking for work, training and volunteering.

**Barriers to returning to work**

A 2009 report by the Mental Health Foundation notes that most long-term sickness absence is due to mental health problems such as stress, depression and anxiety and many employers fail to support staff returning to work after suffering from depression. Line managers and HR managers were found to prefer making work adjustments for those with cancer and heart disease over those with depression, despite many of those who had experienced depression reporting high job strain and that the cause of their illness was often work related.

**Advice and support**

Early access to advice and support is extremely important in helping people with mental health problems maintain and return to their jobs. Community mental health teams (CMHTs), day care and other rehabilitation services have a central role in helping people maintain or access employment and link with employment agencies and employers, including Jobcentre Plus. Indeed, a recent study by Grove *et al* (2005) found no evidence for discouraging clients from pursuing vocational options, regardless of their diagnosis, symptoms, hospitalisation history, level of social functioning or employment history. In fact, working can reduce symptoms, improve social skills, and enhance opportunities.

People with mental health problems need a range of employment options, as needs vary. Some will not be able to work in the open labour market, and will continue to need alternative options. Work options, including sheltered and supported employment, will be discussed further in section 8.
3 How mental health impacts on people’s access to and use of careers and advice services
Guide for advisers

This section outlines some of the issues and barriers related to full access to careers and advice services by adults with mental health problems. An individual’s diagnosis can impact on their use of careers and advisory services and, consequently, affect the appropriateness of the advice provided. This section considers the following areas:

- adults with mental health problems want advice
- some advisers do not understand the barriers
- what an adviser can do to encourage accessibility to careers and advice services
- the client perspective.

Adults with mental health problems want advice

Research conducted in 1999 indicated that over 40% of adults with mental health problems would welcome help to find paid employment and advice and guidance to access training and education, and 38% wanted careers advice. They wanted, in particular, expert careers advice from people with an understanding of mental health and employment issues.

Some advisers do not understand the barriers

Research indicates that some advisers have a poor understanding of barriers to employment and learning, in particular, the side effects of medication, which can exclude certain types of jobs, and stigma and discrimination. It is also reported that advisers are largely unaware that people with mental health problems have good and bad days, and do not understand the effects associated with this, including the value gained from guidance and opportunities for employment and learning. Other barriers to accessing careers and advice services include a tendency for advisers to either oversimplify or provide too much detail, and a lack of basic information, such as who to contact at Jobcentre Plus.

What the adviser can do to encourage accessibility to IAG services

Primary research carried out by iCeGS in 2007 indicates that the challenge for advisers is to:

- gain the trust of the client; some clients may have problems with authority figures
How mental health impacts on people's access to and use of IAG services

- keep consistency of adviser–client relationship as far as possible; do not keep changing adviser
- motivate people who are disengaged from the labour market, who may be very negative towards learning and work, possibly because of previous experiences; they may see barriers rather than opportunities, and lack focus
- support the client to set realistic and achievable goals; for many clients, the most effective way forward is to aim for small steps, many of which they can achieve independently – for instance, finding their way to the Jobcentre Plus office or planning the bus journey to college
- provide greater flexibility to accommodate clients’ differing abilities on good and bad days
- ascertain what, if any, support networks the individual has.

The research also underlined the importance of outreach activities that contact people in non-institutional settings and environments where they feel comfortable and at ease. There also may be tensions about whether advisers should or should not establish if the client is receiving counselling or other treatment. Advisers must also know about the importance for some clients of advocacy issues.

The client perspective

Some clients may:
- experience lack of confidence and low self-esteem, meaning that they will find it difficult to ask for help, and may even find it difficult to attend an appointment at a place they have not visited before
- have very low expectations of themselves and not be able to set themselves realistic goals
- experience lethargy and lack of energy – these may be a result of their mental health problem or a side effect of medication
- choose not to disclose their mental health problems, or may only partly disclose their problems.
This section describes the relevant policy context in the UK. In recent decades, and in particular since 1997, there has been a substantial change in central government policies towards adults with mental health problems. Much of the change has been related to changes in attitude to social inclusion. This has resulted in new policy and legislation in several relevant fields, but primarily in an increasing drive to encourage more people with mental health problems to access mainstream employment. The contents of this section are as follows:

- the background
- the National Service Framework
- the Care Programme Approach
- mental health legislation
- social exclusion
- other policy and new ways of working
- the Learning and Skills Council (LSC) strategy
- the Disability Discrimination Acts (DDA) 1995 and 2005
- other relevant legislation
- the benefits trap

The background

The government is currently working to ensure a joined-up approach to health and employment policies and a key document for mental health policy is the National Service Framework (NSF) for Mental Health. This was published by the Department of Health in 1999. It is part of a wider ‘modernisation agenda’ that promotes joined-up approaches, partnership working and social inclusion in all public services.

Mental health services were clearly in need of modernisation by the end of the 20th century. Since the 1960s, it had been government policy to close the large psychiatric hospitals, which were mostly built in the mid 19th century. Closure took longer than expected, and the local community services intended to replace the large, long-stay hospitals were slow to develop. The 1990s saw many large hospitals finally closing and the beginnings of a comprehensive and integrated community care service.
As well as more recent development to mental health services in the UK (as in the subsection below) there has been increased international interest in mental health. The European Union recommends more government support for mental health in the workplace. A 2009 report calls on the commission to,

Require businesses and public bodies to publish annually a report on their policy and work for the mental health of their employees on the same basis as they report on physical health and safety at work.

The National Service Framework

The NSF for Mental Health is a 10-year programme (from 1999–2009), and is based around seven standards.

The seven standards can be summarised as:

- health and social services should promote mental health and combat discrimination
- service users with common mental health problems should have their needs assessed and be offered effective treatment in primary care
- service users with a common mental health problem should have 24-hour access to services, receive adequate care, and be able to use NHS Direct
- service users on the Care Programme Approach (CPA) should receive care that optimises engagement, prevents crisis and reduces risk; they should also have a copy of their care plan, which should be regularly reviewed. They should have access to services at all times
- service users who need it should have access to a hospital bed or equivalent and should receive a copy of their care plan on discharge
- carers who provide regular and substantial care to a person on the CPA should have an assessment of their own needs and their own care plan
- prevention of suicide is to be achieved by implementing the six standards above, and through training, support and the development of audit systems.

NHS trusts are monitored on their performance on achieving the seven NSF standards and there is an annual assessment of their progress. All other, subsequent mental health policies have their roots in the NSF for Mental Health.

The Care Programme Approach (CPA)

The CPA (as it is commonly known) was initiated in 1991 as a care planning system. Originally, it covered all people who are using specialist mental health services. However, in 2008, its application was limited to individuals with a wide range of needs being met by a number of services, or who are considered to be at most risk.

The values and principles that underpin the CPA are:

- the approach to individuals’ care and support puts them at the centre and promotes social inclusion and recovery
- care assessment and planning views a person ‘in the round’ seeing and supporting them holistically across all key areas of their life with the aim of optimising mental and physical health and well-being
The policy context

- self-care is promoted and supported wherever possible
- carers form a vital part of the support and their own needs are catered for
- services promote helpful practice based on fulfilling therapeutic relationships and partnerships between the people involved – the quality of the relationship between the service user and the care co-ordinator is one of the most important determinants of success
- care planning is underpinned by long-term engagement, requiring trust, team work and commitment.

Every service user who is subject to CPA will have a care co-ordinator, whose job it is to monitor and co-ordinate the person’s care. The care co-ordinator will also regularly review and, where necessary, agree changes to the care plan.

Risk assessment is an essential and ongoing part of the CPA process. Care plans should include a contingency plan for what to do in a crisis, or if the service user breaks down.

Service users, who are using specialist mental health services but are not subject to CPA, will usually be under the care of an appropriate professional and there will be an agreed statement of care rather than a full care plan.

Where advisers are working with clients who are receiving specialist mental health services, it would be helpful for them to find out if the client is subject to CPA or not.

Mental health legislation

The 1983 Mental Health Act mostly covers the arrangements for the compulsory detention of people in hospital through various sections of the Act. This is how the term ‘being sectioned’ came to be used for somebody who is compulsorily admitted to hospital.

The 1983 Mental Health Act was recently amended and some changes came into force in 2008. In particular, a new power of supervised community treatment was created. Some patients who are in hospital under a section can be subject to a ‘community treatment order’ (CTO) when they are discharged from hospital.

The numbers on CTOs will be relatively small and the vast majority of clients who require careers and advice services will not be on any form of compulsory order or section. Where the person is on a CTO, advisers will need to check out what this means with the person themself and with their care co-ordinator.

Mind have produced a useful outline guide to the Mental Health Act 1983 (see References – page 71)

Social exclusion

A report from the Social Exclusion Unit in 2004 highlighted that people with mental health problems were one of the most excluded groups in society, with fewer than 25% of adults with long-term mental health problems being in employment. The causes for this
exclusion were felt to be that both stigma and discrimination against people with mental health problems are pervasive throughout society, and that professional mental health workers often have low expectations of what people with mental health problems can achieve.

The report argues for creating sustainable, inclusive communities where everyone has a stake. Being in work and having social contacts are strongly associated with improved health and well-being. The report encourages programmes to challenge negative attitudes and promote awareness of rights.

The role of health and social care is to champion evidence-based practice in vocational services and to enable re-integration in the community. Overall, there is a strong emphasis on giving people with mental health problems a real chance of paid work.

Other policy and new ways of working

The NSF for Mental Health and the modernisation agenda has produced a large number of policies. Section 6 of this guide looks at policies that affect client groups with differing needs, with a particular emphasis on women and black and minority ethnic service users.

All the key professions in mental health – mental health nurses, occupational therapists, psychiatrists, psychologists and social workers – are examining new ways of working to deliver the standards in the NSF. In addition, various new types of worker have recently been introduced. Section 7 of this guide explains the different types of services and workers in the mental health field.

The Learning and Skills Council (LSC) strategy

The LSC strategy for improving education and training for disabled learners includes increasing economic participation through sustainable employment (see NIACE, 2007). The LSC strategy, 2009, stresses a number of areas important to adults with mental health problems who wish to access appropriate learning opportunities, including partnership working, and quality. The strategy endorses the social model of disability and emphasises a number of methods including recovery and person-centred planning.

The strategy also considers the importance of exploration of new models of working with agencies and government departments like the Department of Health to develop ‘holistic cross agency approaches giving individual learners more say in and control over their support and learning provision to maximise the impact and personal benefits of public funding’ (p24).

The Disability Discrimination Acts (DDA) 1995 and 2005

To qualify as disabled under the DDA, a person must have a physical or mental impairment. (The term ‘mental impairment’ covers both learning disabilities and mental health problems/conditions.) In addition, the impairment must have both substantial and long-term negative effects on the person’s ability to carry out normal day-to-day activities.
People with mental health problems may not consider themselves to be disabled, indeed, disability legislation has, in the past, been less well geared towards people with mental health problems. However, the 2005 DDA made the rights and potential benefits from the legislation more accessible to people with mental health problems. In summary, the rights for mental health service users under the DDA include:

- the right not to be discriminated against because of their mental health condition
- the right to have ‘reasonable adjustments’ made in the workplace to enable them to get a job, stay in work, or use services (public and private/commercial).

There has not been much work to date on what ‘reasonable adjustments’ might mean in relation to a person with mental health problems. Flexible working hours, access to support and supervision and a sympathetic, well trained line manager are some of the adjustments that people with mental health problems might find helpful. Individual service users will have their own ideas about what adjustments would make education and employment more accessible for them.

In summary, there are considered to be five forms of disability discrimination in employment:

- direct discrimination
- disability related discrimination
- failure to make reasonable adjustments
- harassment
- victimisation.

The Disability Rights Commission (now Equality and Human Rights Commission) developed useful further information on the DDA 1995 and 2005.

**Other relevant legislation**

Other areas of legislation that relate to mental well being in the workplace are:

- The Health and Safety at Work Act 1974 (HASWA)
- Human Rights Act 1998

**The benefits trap**

People with mental health problems often find their route back into employment blocked by what has become known as the ‘benefits trap’. While they may wish to work, there is great concern that the process of returning to work will adversely affect their benefits, leaving them without income if their return to work is not successful. This is a complex and ever-changing field, and needs the input of a specialist welfare benefits adviser. Welfare benefits are covered in more detail in section 9 of this guide. The government signalled the clear direction for the future in this respect in its policy document *Valuing People* (2001). A key government objective is to support vocational skills development for people with disabilities, by taking them off Incapacity Benefit and helping them into paid work.
New policy developments, 2009

The government announced in 2008 a number of key planned initiatives. These included proposals to replace the paper-based sick note with an electronic ‘fit note’, the government’s paper Improving Health and Work: Changing lives describes these. Other proposals include:

- a National Centre for Working Age Health and Well-being
- health, work and well-being co-ordinators
- a pilot occupational health helpline for small businesses
- a challenge fund to encourage local initiatives to improve workplace health.

The government has announced (March 2009) that a new agency to ensure national mental health policies bring about improvements for patients and carers will start work on 1 April 2009. This new agency – the National Mental Health Development Unit – will succeed the current National Institute for Mental Health in England.

The government is currently (March 2009) planning to make more specialist help available to people facing unemployment, who will be referred to psychotherapists for expert counselling via Jobcentre Plus and other agencies. This initiative is to be established to combat depression and anxiety caused by the recession. During 2009 a network of employment support workers will be set up at every designated centre to give advice about how to get back to work.
5 Working with clients who have mental health problems
Guide for advisers

‘The best advisers are those who strike up a relationship, are not judgmental, understand the client’s world and are not fazed by the client’s behaviour – for example, hearing voices.’
(careers and advice expert)

Empathy, understanding and respect for the condition, and acceptance of the client as they are, are all critical factors in supporting people with mental health problems.

This section focuses on ways in which advisers can work most effectively with people who experience mental health problems. It covers the following areas:

- advisers and clients with mental health problems
- good practice guidelines for advisers
- special issues – confidentiality, crises, disclosure, Disability Discrimination Act (DDA), client issues.

Advisers and clients with mental health problems

For many advisers, much of the information in the section will be a checklist or aide-memoire of routine good practice. Advisers working with clients with mental health problems will often use the same professional skills as when working with any other clients. However, there are many areas in which experienced advisers may want to update their knowledge and techniques for working with these clients.

Mental health problems affect approximately a quarter of the UK population. This means that up to one in four users of careers and advice services are likely to experience some form of mental health problem. These difficulties may be diagnosed, undiagnosed, unacknowledged, disclosed, major or minor.

Crucial to advisers and their effective support of adults with mental health problems is the remit of their organisation, their own job role and the relevant training they have. Effective advisory work with adults with mental health problems usually requires that advisers are well trained and can work with such clients over a period of time. It is important for advisers to remember that people from many professions have an important role to play in supporting adults with mental health problems.
Impartiality and focusing on the needs of the individual are aspects of adviser expertise valued by clients:

‘A lot depends on the interviewers and their skills in interviews and assessments to extract pertinent information and guide a client along the correct pathway for them. This, therefore, will be a bespoke service for each client, and not one that offers a prescribed process for all. Returning to work doesn’t need to be “sold” to what appears to be a ready and willing community. Rather, barriers need to be bridged and firm foundations built with people for a brighter future.’ (Client/service user)

Good practice guidelines for advisers

The following eight points are ones that advisers may wish to use and build on in their work with clients with mental health problems. The continuing professional development action plan in section 11 may also be useful.

1 Be positive about clients with mental health problems
A quarter of all people in England will experience mental health problems at some time. Many of these adults will recover quickly and be able to lead a normal and productive life. Advisers should bear these facts in mind and promote their advice service as one that is accessible and accepting of these clients. Many clients will have experienced discrimination and may be concerned about the stigma attached to their illness. Some may feel uneasy about approaching information, advice, guidance and careers services because they may feel that their illness will not be understood, or that they will be stereotyped. As part of a positive approach, advisers should use language that is positive and straightforward. They should avoid using words like ‘suffer’.

2 Become familiar with some of the common mental health conditions and some common ways in which these may be manifested
These are given in section 1 of this guide. Advisers should be careful not to diagnose a condition themselves, and to avoid jumping to conclusions, labelling or making presumptions based on hearsay. It is critical to bear in mind that individuals’ symptoms will not necessarily conform to a supposed ‘norm’.

3 Be familiar with legal and professional issues that apply to careers and advice practice with clients with mental health problems
Further information on these is given in the second part of section 5, but they include:
- do you know about the relevant sections of the Disability Discrimination Act?
- can you support a client to complete a CV?
- are you familiar with ‘disclosure’ issues, both as they concern you as an adviser and potential employers?
- are you sure about your organisation’s protocols and policies on confidentiality?
- do you know how your clients can be supported in work?
- what does the symbol mean?

4 Work with the client
The critical areas include the following.
- Treat your client as an individual. This is part of every adviser’s professional code.
Working with clients who have mental health problems

of ethics. Each individual will experience different symptoms of illness, and each client needs to be treated as a person and not as a ‘schizophrenic’ or other such label. It is essential to avoid stereotyping and labelling. Knowing a client’s diagnosis is not always relevant, and can occasionally limit an adviser’s work. If a diagnosis is volunteered, advisers should explore the condition as it affects the individual – for example, by asking ‘How does this condition affect you?’

- **Empowerment.** With some groups of clients who have experienced mental health problems, empowerment may not be easy. Some clients will have experienced many months of passively ‘doing what they are told is best for them’. Encouraging clients to make their own decisions and to take control of their career planning may take some time and relationship building, but advisers can support their clients to start taking some actions themselves. For instance, advisers can encourage their clients to talk through their journey to a community centre.

- **Establish the client’s needs.** This may be particularly challenging, especially if the client has not clearly defined her/his mental health problems. These needs may be physical and/or psychological. At all stages an adviser should check out their understanding with the client. If a client discloses the nature of their mental condition, check with them what the condition means to them, how it affects them, and what they think they need.

- **Privacy.** Many clients will prefer to talk to an adviser in a private area where conversations cannot be overheard. However, on some occasions an adviser may want to keep the door of the private room partially open, to ensure that colleagues are available if any help is needed. Advisers should consult with colleagues to determine the best arrangement of furniture and access.

- **Build a rapport and develop trust.** This may require the adviser to be open and accepting of unusual behaviour. But it is also important to challenge and discuss some types of behaviour, where appropriate, for example, ‘I notice that you are not looking at me…’ Also important are using active listening skills, summarising and feeding back to the client, and reflection. Important too is to be reassuring and to work with the client to develop positive strategies for support. This is a particularly challenging area with some clients, and appropriate adviser training is required.

- **A caveat.** Some clients may have spent a long time talking about themselves and their problems. They may be ‘stuck in a rut’ and find it hard to explore ways of moving on.

- **Take time.** For many people with mental health problems, relationship building is a long process, and it may take several interviews to enable a client to move on.

- **Small steps.** For many clients, action planning in a series of small steps is best. Supporting a client to be confident enough just to go outside their home may be a significant achievement.

5 Work within the boundaries of the adviser role

Often practitioners find it useful to define their role to the client in terms of what they can and cannot do to support them. Advisers may want to clarify with their manager any grey areas. Advisers need to be clear not only about their personal competence in client interactions but also about the remit of their organisation. An adviser should never attempt to diagnose or solve a client’s mental health difficulties: many clients will need additional support from counsellors and medical experts. In summary, key role boundary issues are:

- clarity of adviser role
- professional training undertaken
• understanding of the boundaries between counselling, guidance, advice and advocacy
• clear appreciation of relationships with clients (including out-of-hours relationships)
• advisers should not give ‘quasi’ medical advice.

6  Be aware of personal strengths and weaknesses
Some clients with mental health problems can be enormously challenging. Examples include clients who give no direct eye contact, and clients who say that they have broken the TV ‘because it was talking to me’. Advisers should reflect on their personal ‘blockers’ and consider best ways forward. Working with this group of people can bring some advisers out of their own ‘comfort zone’ and advisers should not be embarrassed to seek out specialist support, including support described in section 7. One useful technique (described in Learners with Mental Health Difficulties) is for advisers to list their misgivings and rationalise them. Further information is given in section 11.

7  Referrals to and working with others
Lists of specialist organisations are given in section 7 in this guide. Advisers need to find a balance between referring a client to another organisation or adviser to ensure they have the best possible resources and support, and passing a client on, thereby denying them the opportunity to build constructive relationships. Advisers should, as far as possible, be aware of the substantial support the client may have received (and may continue to receive) from mental health practitioners, especially including learning programmes.

8  Advisers should look after themselves
Interactions with challenging clients can be exhausting and stressful. There can be serious practical and emotional issues with which advisers may need support. Some of these are considered in the ‘special issues’ section below. Advisers should build in time for reflection and discussions with colleagues and experts, as necessary. Advisers should find ways of dealing with their own emotions after particularly challenging clients. Some advisers find it good to go for a short walk in the fresh air after such a challenge. Most advisers will find it useful to talk to colleagues soon after a ‘harrowing’ interview. They should also ensure that they have an adequate professional support system, perhaps involving supervision (see section 11).
Special issues

This section contains further information on:
- clients with out-of-date and/or unrealistic ideas
- confidentiality
- crisis situations
- Disability Discrimination Act (DDA)
- disclosure to the adviser
- disclosure to a potential employer or opportunity provider
- extra help for the client, including the symbol
- other legal matters
- supporting clients in and into work.

Clients with out-of-date and/or unrealistic ideas
Advisers should note that clients with mental health problems may have been out of the labour and learning markets for a long time, and may not know how things have changed. For instance, there may be a lack of unskilled jobs in some areas. Their job search language and techniques may be outdated. Clients will need special support for this, including short ‘return to work’ programmes.

Most advisers are experienced at dealing with the client with unrealistic job aims, but additionally advisers may need to ask themselves if the lack of realism is:
- related to the client’s mental health condition, or
- related to the client’s absence from the job market for some time, or
- a strategy used purposefully by the client to avoid having to make decisions.

Advisers may need expert help on occasions in this respect.

Confidentiality
Advisers should:
- check their organisation’s confidentiality policy
  ▪ does it include access to information by support staff?
  ▪ does it include peer/case study discussions by client name?
  ▪ is confidential information kept locked up?
  ▪ are notes labelled ‘confidential’?
- ensure that the client gives consent (in writing is best practice) to giving their name to others, for instance, when making referrals
- know that other professionals working with the same client will only be able to share information with the client’s consent
- be aware that some occupations (for example, nursing) may have additional confidentiality codes of conduct that relate to fitness to practice
- not use the client’s name with others (unless specific consent is given by the client) – for instance, in seeking further information on behalf of a client
- not use descriptive information about a client that identifies a client by default
- always break confidentiality if a crisis situation occurs (as below).
Crisis situations
An adviser is not bound by any confidentiality agreement if he or she considers that:
• the client presents a danger to self or to others, or
• has lost touch with reality to the extent they may be vulnerable to harm, or
• a criminal act has taken place.

This kind of crisis is rare. Behaviour indicators for crisis situations may include extreme agitation, volatility and violence. One way of handling this type of situation, as described by a manager with expertise in working with clients with mental health problems, is for the adviser to tell the client, ‘I am seriously concerned about your behaviour and I am going to telephone your GP’. The adviser would also consult a colleague. In extreme situations, the adviser may need to contact the police.

Disability Discrimination Act (DDA)
The DDA (2005) protects clients with mental health needs from unfair discrimination. This can take place in two ways: treating clients ‘less favourably’ than other people, and failing to make ‘reasonable adjustments’ so they are placed at a substantial disadvantage to other people because of their disability. A reasonable adjustment might be that an employee with mental health problems is able to start work late if their medication makes it difficult for them to get up early.

It is also worth noting that the changes to the DDA (1995) in December 2005 mean that mental illness does not need to be a ‘clinically well-recognised’ condition to be covered by the Act. This means that the conditions of anxiety, stress and depression may be sufficient to cover a person under the DDA, as long as there is a long-term effect (at least a year) on the person’s ability to carry out everyday activities.

Disclosure to the adviser
This is linked closely with confidentiality. If a client discloses that she/he needs special support, it is essential to obtain the client’s permission before contacting other agencies with the client’s details. However, if the client is emotionally distressed but does not wish to access other services, this is their legal right and it should be respected. Factual notes should be recorded by the adviser, and the client should be informed that s/he has access to them.

There could be many reasons why clients do not wish to disclose details of a known mental health problem to an adviser, including a fear that they will be seen to be complaining, or that it would cause embarrassment, or that they would be stereotyped. A good rapport with an adviser, perhaps achieved over several interviews, could encourage disclosure.

Disclosure to a potential employer or opportunity provider
If a client is not asked about their mental health problems when applying for work then the client is not obliged to disclose them.

If the client is specifically asked about their health or a gap in their employment history, and the client does not disclose, the client can be dismissed for deliberately withholding information.
If no questions are asked and no disclosure is made, the employer may be able to dismiss the client/employee with appropriate notice if difficulties occur within a one-year period. There is some evidence that, while advisers would encourage their clients to ‘disclose’ information to a potential employer, many successful job hunters from higher education with mental health problems think it better not to volunteer mental health information. This strategy of ‘non disclosure’ may be more effective with smaller employers, as these do not always have an application form that demands health information. Ultimately, it is the client’s decision whether or not to disclose to an employer or potential employer.

**Extra help for the client, including the sign**
For clients with defined mental health problems who are willing to disclose and to be assessed by a consultant or specialist GP, and who have also been unemployed for over a year, Jobcentre Plus can provide additional resources to support them to start work, or to continue working in an existing situation.

The client is also guaranteed an interview with employers supporting the sign (as long as the applicant meets the requirements for the job). Companies that display this sign are committed to offering an interview to job applicants with a disability who meet the job requirements.

**Other legal matters**
Two other legal areas are particularly important.

- **Data protection** (see also section on confidentiality). Advisers should keep only the minimum of notes necessary and should ensure that access to these is restricted. Advisers may need to inform potential employers of this legislation on behalf of their clients. A draft part of the data protection code of practice on employment practices, published in December 2003, states that information on workers’ health is ‘sensitive personal data’ and employers need to know that only appropriate access should be given to records related to mental health.

- **Health and safety.** It is a general requirement of employees to disclose any condition that may have implications for health and safety in the workplace. Employers have a duty to undertake risk assessments and manage activities to reduce the incidence of stress at work. The Working Time Regulations 1998 may affect some employers.

**Supporting clients into and in work**
There are some specific areas in which an adviser can give appropriate support to clients to move on into the paid labour market. These include:

- supporting the client to develop their career plans in small steps, if appropriate, considering the range of opportunities from confidence-building programmes to voluntary work to applications for paid employment (as in section 8 of this guide). Many clients will benefit from moving through a ‘transitional labour market’ continuum, meaning that for many clients voluntary work may prove a good first step
- supporting clients with specialist advice and guidance on CV building and how to handle interviews
- being aware of local employers who are positive about disability
• being able to signpost the client to specialist organisations that can help (see section 7 of this guide)
• knowing the contact arrangements for their appropriate Jobcentre Plus, to enable the provision of suitable client support in the workplace.

Providing support for a client in work is often outside the adviser’s official remit. However, advisers may be able to use signposting arrangements, together with HR resources within the employing organisation, to support the client to retain employment.

Special areas to be aware of include:
• people who have experienced long periods of unemployment may lose a strong and supportive social network by starting work. They may experience hostility from old friends who remain unwaged and who may consider that the successful job hunter has ‘broken ranks’
• advisers can sometimes support a client who is in work by sending them a simple text message, indicating that support is still there
• clients with mental health problems may have spent a long time focusing on their ‘self’. In work a new focus is needed, and some people will need support to make this adjustment.
The contents of section 6 are:

- black and minority ethnic clients
- women
- offenders
- other groups of adults with mental health problems.

The section looks at clients from different backgrounds who have mental health problems and wish to consider learning and work. The 21st century has seen a greater focus on antidiscriminatory practice within mental health care. It is acknowledged that some groups of clients have received a less than adequate service in the past. While the blame for this can be placed at the door of mental health services, it is important also to recognise the broader societal aspect to the discrimination involved. Many adults in these groups can experience ‘double discrimination’.

**Black and minority ethnic clients**

It is generally accepted that black and minority ethnic service users have experienced a poor level of mental health service. Peter Ferns summarises the research and highlights various key issues as follows:

- an over-representation of black people in the psychiatric system
- an increased likelihood of black people coming into the system through a compulsory route
- lack of preventative and after-care mental health services appropriate for black and ethnic minority communities
- over-use of drugs and physical treatments with black service users, rather than talking therapies
- higher rates of diagnosis of psychosis for black people, particularly schizophrenia
- increased likelihood of being racially stereotyped by professionals in decisions about ‘dangerousness’.

Because of such experiences, it is possible that black and minority ethnic service users with mental health problems may be very wary of services, and also reluctant to talk about their experiences within mental health services.
Client groups with differing needs

The Department of Health has taken steps to tackle these issues through a number of policy reports and initiatives. Mental health staff in the NHS are expected to attend a national Race Equality and Cultural Capability training programme.

Women

A Department of Health (2002) report looked at the current state of mental health care for women. Some key messages were:

- most mental health care for women is provided in mixed-sex environments
- there is significant variation across the country in the provision of women-only sessions/services
- there has been serious criticism of mixed-sex inpatient care in relation to women’s safety from violence and abuse
- women who have used women-only services speak highly of them
- women express an overwhelming sense of ‘not being listened to’.

This report also gave guidance on developing gender sensitive services. Some key messages are:

- gender is a key issue that influences an individual’s experience of the world, and gender issues therefore should be incorporated into research, service planning, delivery and evaluation
- it is important to continue to recognise the uniqueness of the individual, to ensure that service planning and delivery are sensitive to gender
- there is a need to provide single-sex services in some instances; to turn these aspirations into action, organisational and individual values and behaviours need to be addressed and challenged
- social inequality in the home, at work and in society at large is an important factor in relation to the mental ill-health of women
- the provision of single-sex services is part of a wider agenda in the NHS; the issue of safety is a crucial one for women who are using mental health services; in some areas, there may be specialised services for women.

The 2007 household survey showed that over a fifth of women (21.5%) suffer from a common mental disorder (CMD), typically depression or anxiety. The research noted that the largest rate of increase in CMD between 1993 and 2007 was observed in women aged 45 to 64 whose rate rose by about a fifth.

Offenders

There is a high level of mental illness within the offender population. While there may be considerable debate about the causes and effects of this, and the best ways in which offenders can be offered information, advice and guidance, it is important that advisers are aware of the particular issues, one of which relates to women offenders and mental illness. The Office for National Statistics published a report on psychiatric morbidity among prisoners in England and Wales in 1998 (Singleton et al., 1998). This found that, in the 12 months before entering prison, about 20% of male prisoners, both remand and sentenced, had received help or treatment for a mental or emotional problem. The rate among female prisoners was double: 40%.
Other groups of adults with mental health problems

Specific guidance has also been issued by the Department of Health (2002) in relation to modernising mental health services for deaf people, as described in the report *A Sign of the Times*.

There may be specific issues to address for people with mental health problems who live in very rural parts of the country. A particular issue will often be social isolation, with poor transport links leading to lack of opportunities to get out, socialise, or gain access to education and employment.

It is also important to note that lesbians and gay men may have had difficult experiences in using mental health services. Throughout the 20th century, homosexuality was classified as a disease, only being dropped from the World Health Organisation’s International Classification of Diseases (ICD) in 1992.

Many older people experience difficulties within the labour market: for instance, following redundancy. About 50% of claimants of Incapacity Benefit are aged over 50, and half of these have mental health problems.

Overall, it is important to treat each person as an individual, while acknowledging that certain groups of people will have had different experiences of receiving mental health services.
This section gives further information about specialised support available for adults with mental health problems. It also considers the crucial questions of when, how and why an adviser may wish to refer or signpost a client on. Further information on referring clients to vocational training and employment related opportunities is given in section 8. The contents of this section includes:

- the potential support network available to clients
- making contact with potential support services
- why, when and how should advisers refer clients.

The potential support network available to clients

It is important to realise that approximately 90% of people with mental health problems receive all their treatment from primary care services; essentially this means their general practitioner and a broad level of ‘generic’ medical support personnel. As such, their general practitioner (GP) will be the key person in relation to their care. They may also be in touch with other members of the primary care team – possibly with a counsellor employed as part of the team, or a primary care graduate worker. Primary care graduate workers have been employed since 2004 to help GPs manage their mental health workload by offering short courses of therapy.

For people with mental health problems who are receiving specialist mental health services and who are assessed to have a wide range of needs and be at most risk, the key person will be the care co-ordinator in relation to their care plan, which is part of the process known as the CPA (Care Programme Approach). These people will also normally have been assessed at some stage by a consultant. The care co-ordinator has the responsibility for co-ordinating all aspects of the care plan. They may also have input in providing services as part of the care plan. The care co-ordinator will be a member of the mental health team that is directly involved with the service user (or ‘client’). This means the care co-ordinator could be a mental health nurse, an occupational therapist, a psychiatrist, a psychologist or a social worker – whoever is deemed most appropriate for the person’s care needs. These five professions traditionally comprise the multidisciplinary mental health team. For people with mental health problems who are receiving specialist mental health services, but are not under CPA, an appropriate professional will act as their key contact or ‘keyworker’.
There are a number of services that could either be in touch with a client (or service user) or to which a client could be referred. Referral systems will vary from service to service. The diagram that follows shows how a service user who is using specialist mental health services might be in touch with a variety of different services. Advisers should check what is available within their own areas as the availability of voluntary sector services varies considerably from area to area.

*The statutory sector refers to organisations established by or founded upon law, official or accepted rules. Examples include the Local Education Authority (LEA) or Health Partnership Trusts.*

**Making contact with potential support services**

The NHS trust that provides mental health services for a locality/area will have contact details for all statutory mental health services.

With regard to the voluntary sector, most areas have directories, which are produced by the key voluntary sector organisation (usually called the Voluntary Sector Forum or the Community and Voluntary Sector Forum). Sometimes there will be a separate directory just for mental health services.

To find out about a local Voluntary Sector Forum or Community and Voluntary Sector Forum, you can contact NAVCA (The National Association for Voluntary and Community Action) at [www.navca.org.uk](http://www.navca.org.uk)
The role of the Disability Employment Adviser (DEA)
The DEA is a specialist role in Jobcentre Plus. Besides helping clients with the various schemes: Work Preparation, Workstep, Job Introduction Scheme and Access to Work (described in section 8), and also giving advice to individuals with a disability who may be in work or seeking work, the DEA can access specialist support and training. DEAs provide information about the Disability Discrimination Act and the Disability symbol. DEAs can also support clients who have ‘failed’ their Personal Capability Assessment (PCA).

Other potentially useful contact points are:
- **Improving Services for Learners with Mental Health Difficulties**: Regional Networks [http://www.niace.org.uk/mentalhealth](http://www.niace.org.uk/mentalhealth)
- **Mind** – visit [www.mind.org.uk](http://www.mind.org.uk) to find out details of any local Mind groups (Mind is the National Association for Mental Health in the UK, and campaigns on behalf of those with mental illness; local Mind groups are autonomous, but linked through national Mind)
- **Rethink** – visit [www.rethink.org](http://www.rethink.org) to find details of any local Rethink groups
- **MDF: the Bipolar Organisation** (formerly the Manic Depression Fellowship) – [www.mdf.org.uk](http://www.mdf.org.uk)
- **British Association for Counselling and Psychotherapy** – [www.bacp.co.uk](http://www.bacp.co.uk)
- **Samaritans** – [www.samaritans.org](http://www.samaritans.org)
- **Together service-user directorate** – [www.together-uk.org](http://www.together-uk.org)
- **beat** – beating eating disorders – [www.b-eat.co.uk](http://www.b-eat.co.uk)
- **National Phobics Society** – [www.phobics-society.org.uk](http://www.phobics-society.org.uk)
- **Alcoholics Anonymous** – [www.alcoholics-anonymous.org.uk](http://www.alcoholics-anonymous.org.uk)
- **Gamblers Anonymous** – [www.gamblersanonymous.org.uk](http://www.gamblersanonymous.org.uk)
- **Narcotics Anonymous** – [www.ukna.org](http://www.ukna.org)
- **The Compassionate Friends** (bereavement counselling) – [www.tcf.org.uk](http://www.tcf.org.uk)
- **Cruse** (bereavement counselling) – [www.crusebereavementcare.org.uk](http://www.crusebereavementcare.org.uk)
- **The National BME Mental Health Network** can provide information and events, details from [http://www.bmementalhealth.org.uk/](http://www.bmementalhealth.org.uk/)
Specialised support – including further signposting, contacts and referrals

- **TAEN** – The Age and Employment Network, which can help provide information related to older people. It does not offer client advisory services – www.taen.org.uk

**Why, when and how should advisers refer clients?**

This is a complex matter and an area in which there are no ‘right’ answers. Clients report that they generally prefer to keep contact with one adviser, rather than be passed from pillar to post. However, there are lots of good reasons to refer a client to others: s/he may benefit from specialist support, as well as the ‘home’ adviser; another adviser may be able to support the client better. Some considerations are given below.

---

**When to refer clients**

- Referral is always a matter of judgment: what is in the best interests of the client? Discuss with colleagues and managers when you have uncertainties.
- Be clear what you consider to be the client’s needs – for example, medical support, care support or specific employment-related support (like access to residential employment training through a Disability Employment Adviser at Jobcentre Plus). Discuss with the client and take agreed notes of the actions you will take.
- Agree with the client the method and timing of a referral. Bear in mind the importance of empowerment for the client – some clients may wish to be given a list of contacts to phone themselves. For other clients, a telephone discussion by the adviser with another agency will be appropriate. However, this must be done with the client’s knowledge and permission if any personal details are given.

---

There may be a few clients who may like to ‘try out’ many advisers. Others may continually ask about different career areas. These behaviours may be indicative of a mental health problem, but the adviser should seek out further advice from a manager and/or a specialist organisation or colleague, and avoid jumping to conclusions. These issues reinforce the importance of advisers and agencies working closely together to support clients in a joined-up way (confidentiality allowing).
8 Learning and working opportunities for adults with mental health problems
Guide for advisers

This section of the guide briefly examines the learning and working opportunities, including ‘models’ of employment, available to clients with mental health problems to help them gain employment. The contents of this section are:

- the context
- support for clients before they enter employment and training
- models of occupational interventions
- summary table of occupational interventions
- further help and advice.

The context

It is important to place these schemes within the national policy context. Policies are emphasising more and more the importance of providing opportunities for adults with disabilities to access mainstream employment. An example of this is the Learning and Skills Council (LSC) strategy for Mental Health, which has prioritised areas including increasing economic participation through sustainable employment (NIACE, 2007). The LSC strategy states that, by September 2015 England will be an international exemplar in providing learning and skills opportunities for people with mental health difficulties.

The government-supported schemes such as Workstep, Pathways to Work, Work Preparation Programme and the New Deal, which are all parts of the Welfare to Work agenda, are currently being reviewed and are likely to be developed further or replaced in 2009 and 2010. New programmes will replace Workpath in October 2010.

Advisers should bear in mind that there are many employment schemes funded by local authorities or health trusts, in addition to the central government funded schemes. Hence there may be a ‘postcode lottery’ of opportunities availability, but this may also provide a chance for agencies to work together with potential funders to develop further local opportunities.
Support for clients before they enter employment and training

Clients with mental health problems often need extra support to give them confidence and encourage them to redevelop skills before they are ready to consider entering the job market. This kind of support can be categorised as **day activity and support**, which involves therapeutic activity and daily structure as a first step into employment. This type of employment support can be offered at day hospitals, day centres, community mental health team (CMHT) bases or resource centres, drop-in centres and social clubs. This type of support is often substantial and advisers should ensure they are aware of and, if appropriate, build on learning and similar programmes available from mental health specialists.

Models of occupational interventions

A number of interventions can be made to encourage employment and training for clients with mental health problems.

**Mainstream employment**

For adults who have been out of the mainstream labour market for some time, it is often very difficult to move directly into a conventional job. Further information is given in the companion guide, *Mental Health Issues: Guide for managers*. Getting mainstream employment is easier for those whose absence has been short and whose mental health problems are not severe. Positive steps include:

- advisers working with disability positive employers
- close liaison with Disability Employment Advisers from Jobcentre Plus
- work with groups of Human Resources (HR) representatives from organisations within the region.

**Sheltered employment**

Sheltered employment is distinctive in that it is usually in a ‘protected’ setting, separate from people who do not have a mental illness or disability. Traditional sheltered working provision is declining rapidly, mainly due to a government decision from April 2001 to remove the requirement on individual authorities to pay 25% towards the cost of sheltered workplaces. This approach is also criticised for being outdated, too paternalistic, discouraging integration into the wider community and employment market, offering a limited range of unskilled activities and few opportunities for career progression, and offering salaries at minimum wage levels.

**Social enterprise organisations**

Social enterprise organisations can also provide opportunities for clients with mental health issues to enter the job market. A social enterprise is a company that has charitable aims. A social enterprise can operate in many fields but it does not necessarily provide support to individuals with mental health problems. Examples of social enterprises, which operate with social goals as well as or instead of business goals, include: the social firm (which operates in a competitive market); development trusts; cooperatives; work crews; credit unions, and community businesses. The government's *Annual Small Business Survey 2005* and existing data for the social enterprise sector show there are at least 55,000 social enterprises in the UK, with a combined turnover of £27 billion per year. In 2005 there were more than 1,550 jobs in this sector, of which 915
were filled by disabled people. It should be noted, however, that 199 (nearly 21%) of the 915 disabled people worked less than 16 hours per week. In 2007 one major supplier of sheltered employment, REMPLOY, announced that it will closing 32 of 83 sheltered factories run and the merger of 11 others with existing establishments.

For more information about social firms go to: www.socialfirms.co.uk/index.php/Section2.html

To find out more about social enterprise firms visit: Social Enterprise Coalition www.socialenterprise.org.uk/

Training and education

Training and education emphasise the development of a client’s capability to work. This is particularly important when one-third of people with mental health problems have no qualifications at all, and this lack of qualifications can have a severe impact on people’s opportunities for employment.

One way to provide training and education to clients with mental health problems is through a clubhouse. These are member-run facilities and offer a friendly environment where individuals with long-term mental health problems can regain confidence, overcome isolation, feel valued, and develop personal and work-related skills. Members of clubhouses have a fundamental role, in partnership with staff, in planning and carrying out all activities necessary to run the clubhouse. In 2004, 26 clubhouses officially operated in the England, but the majority of these were situated in the south east.

For more information about clubhouses go to International Centre for Clubhouse Development (ICCD) www.iccd.org/default.aspx

For examples of clubhouses go to the Scotia Clubhouse website: www.gamh.org.uk/gamhscotia.html

Work rehabilitation/vocational training

A further way to provide training and education to clients with mental health problems is through work rehabilitation/vocational training. Models based on preparing people for work and training are often inter-related as a means to introduce/re-introduce people into employment. These types of services may act as a catalyst to encourage people with mental health problems to build up skills and confidence as part of the rehabilitation process, particularly in supported settings. Work preparation offers specific help to overcome work-related barriers and enable individuals to return to the labour market following a period of unemployment. Specific programmes can help identify the most suitable activities, which could include work experience, learning new skills, or updating old skills and building confidence. Contracted providers deliver the service either at fixed sites or in the workplace with local employers, including group settings with support.

The Jobcentre Plus offers an individually tailored work preparation programme to help people prepare for work following a long period of unemployment or sickness. It can also help people who are at risk of losing their job because of mental health problems. It is tailored to suit individual needs and usually involves doing short unpaid work experience with a local employer. The programme runs over several hours, days or weeks – on average for between six and 13 weeks, depending on whether it is undertaken on a part
Learning and working opportunities for adults with mental health problems

or full-time basis, with a report produced at the end to inform an action plan to achieve stated goals.

**Supported education** is where people with expertise in mental health problems give advice and support to people who wish to undertake training and education. These experts can also give advice to the provider. The key features of this kind of support include extra support within the education environment, flexible course design, and a commitment to gradual progression.

Supported education programmes may involve developing skills for employment and pre-vocational skill areas, personal development, work preparation, and occupational skills, and can be delivered in a wide range of settings. These may include further education (FE) colleges, adult and community education facilities, Workers Educational Association (WEA) provision, government-funded skills training programmes, universities, medium and high secure psychiatric facilities, and mental health facilities, or a combination of any of the above.

Another model of employment that has the benefits of building employment confidence without threatening welfare benefits is **voluntary work or voluntary work placement**. This kind of work is usually unpaid and does not affect welfare benefits entitlements. The main benefits include boosted self-esteem; confidence building; developing new skills, providing a structured activity, and demonstrating enthusiasm and commitment to potential future employers. The advantages of voluntary work are considerable for many adults with mental health problems, as it provides a structured social context in which people can make new relationships and sometimes discover that other people have similar situations to their own.

Further information about volunteering can be found on the Volunteering England website [www.volunteering.org.uk/](http://www.volunteering.org.uk/).

**Supported employment**

Supported employment is where a person with mental health problems is given help to find a job within a real work setting, and is provided with support in the form of advice and guidance and constructive feedback when needed. This support could take the form of a job coach. The terms ‘sheltered and supported employment’ are part of the Workstep programme. The delivery of these schemes varies in different parts of the country. As an example, in Derbyshire Remploy are the only provider of sheltered employment, at their Chesterfield factory – all other Workstep providers support customers in mainstream employment only.

**The Individual Placement and Support (IPS) model** involves assessing vocational skills and then attempting to place people in employment settings that are consistent with their abilities and interests, where they can develop their skills in the work environment while being provided with ongoing support. The IPS model is usually delivered through job brokers, Workstep or existing voluntary and statutory employment schemes such as New Deal for Disabled People (NDDP).

The seven key principles of IPS are:

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. Support is time-unlimited and individualised to both the employer and the employee  
7. Welfare benefits counselling supports the person through the transition from benefits to work.  

(Adapted from Bond et al, 2008) From the Sainsbury Centre for Mental Health, 2009.

Supported employment programmes such as Workstep emphasise progression to unsupported jobs for clients. Workstep, which began in 2001, provides help to people who face complex barriers to getting and keeping a job, but who can work effectively with the right support. It enables eligible disabled people to work within a commercial environment and, whenever possible, progress into open employment. The Workstep provider will introduce the individual to their manager and colleagues and maintain contact to ensure everything is going smoothly. A development plan is agreed with the employer and the individual to help ensure they have the necessary training and support to develop. The Workstep programme sets targets for providers to progress into open employment at least 10% of people formerly on the supported employment programme and 30% of new entrants to the programme, over two years. Under Workstep the individual ‘client’ will be paid the same wage as others who do the same job.

Research suggests that the IPS model of employment is by far the best-rated model because of its ‘real’ work setting, with support provided only when it is needed. Many studies argue that models that follow the evidence-based principles offer the best form of support into employment for people with mental health problems. In research covering 12 randomised controlled studies, nearly two-thirds of individuals with psychiatric disabilities who were assigned to supported employment attained competitive employment, compared with less than a third of those assigned to other vocational programmes.

Residential training for disabled adults helps adults aged 18 or over who are long-term unemployed disabled people secure and maintain jobs or self-employment. The training takes place in a residential setting by staff members with specialist knowledge of disability issues. The training courses and programmes are tailored to assist trainees in securing employment through a combination of guidance, work experience, vocational (work-based) training and qualifications. The length of course varies but none are longer than 52 weeks. The scheme is currently run through nine specialist centres and is currently only available in England.

New Deal for Disabled People (NDDP) helps overcome the barriers that prevent clients from finding work. NDDP is accessed through Jobcentre Plus. Job brokers from the public, private and voluntary sector work with clients and employers to match clients’ skills to vacancies, help them compete in the labour market, and help them find and keep employment.

Pathways to Work is a developing scheme operating in specific areas to provide focused support to help people claiming incapacity benefits to move back into or closer to the labour market. All individuals making a new or repeat claim for Incapacity Benefit will automatically be entered into the Pathways to Work scheme, which entails attending an initial work-focused interview with a personal adviser. Many of these individuals will then attend another five work-focused interviews with the same adviser, who will help
them to identify future life and work goals and any barriers to achieving them. These discussions result in an action plan detailing any activities to be undertaken to strengthen the individual's job prospects. Pathways to Work is delivered by Jobcentre Plus in some districts. In the remaining Jobcentre Plus districts, Pathways to Work is delivered by the private and voluntary sector. The organisations that carry out the programme are called 'providers'.

**Job Introduction Scheme (JIS)** is designed to help people who are looking for work, or are about to start a job, who have a disability that may affect the kind of work they can do. The scheme is run through Jobcentre Plus, and allows the employer to receive a grant for the initial period of employment – they normally receive up to £450 [March 2009], although it cannot be used in conjunction with any other employment support. The funding support given to employers could help to pay wages or other employment costs for a certain period of time – usually the first six week of a new job for someone who has had mental health problems. The work should be due to last for six months or longer and applications for JIS need to be made before the individual starts in the job.

**Access to Work (AtW)** is a programme that helps disabled people and their employers to overcome practical barriers to their staying in employment. Examples of practical support include the employment of a support worker, help with travel costs and for a communicator at job interviews if required. People with mental health problems may be able to take part in AtW if they are in a paid job, unemployed and about to start work or self-employed. The disability or health condition experienced must prevent the individual from doing parts of the job.

Another form of supported employment, which is closely linked with clubhouses (described earlier), is **transitional employment**, where members are offered paid work, usually on short-term contracts. Transitional employment schemes do not move people from benefits, but are viewed as a useful step towards permanent employment. The ownership of the job usually rests with the clubhouse, which allows the client to work more flexibly and without the threat of losing benefits. This is considered one of the most successful aspects of the clubhouse approach.

**Self-employment and enterprise**
The Mental Health and Social Exclusion report (2004) argued that self-employment and enterprise offered the most practical means of re-entering the labour market for mental health clients. Types of support for becoming self-employed include Business Start Up, which is administered by Jobcentre Plus and Business Link. Business Link offers information, advice, support and funding to people starting and developing a business. It is a government initiative, funded through the Department of Trade and Industry (Department for Business, Enterprise and Regulatory Reform).

The following tables are adapted from one produced by the Department of Health (2003), and provides a useful categorisation and summary of the key models of interventions.
Learning and working opportunities for adults with mental health problems

<table>
<thead>
<tr>
<th>Table 1: Type and focus of interventions – sheltered employment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social firm</strong> – a business created for the employment of people disadvantaged in the labour market. At least 30% of employees should fit this description. Work opportunities should be equal between disadvantaged and non-disadvantaged employees. Types of social firm include:</td>
</tr>
<tr>
<td>• <strong>community businesses</strong> – overseen by a group of directors whereby profits are invested in its employees</td>
</tr>
<tr>
<td>• <strong>co-operatives</strong> – a legal structure for a company owned and managed democratically by its employees.</td>
</tr>
<tr>
<td><strong>Sheltered employment</strong> – people with disabilities/disadvantages are engaged in work with other people with disabilities/disadvantages. The government (2007) regards this option as less helpful for disadvantaged adults and is encouraging people to enter mainstream employment.</td>
</tr>
<tr>
<td><strong>Sheltered workshop</strong> – clients are engaged in work activities in a sheltered setting and, for a number of reasons, do not receive a wage at the going rate for a job, but might receive Permitted Earnings (formerly, Therapeutic Earnings).</td>
</tr>
<tr>
<td><strong>Work crews</strong> – working (building, decorating, furniture removals) in small groups of people with disabilities. Little used in UK, apart from in some sheltered settings.</td>
</tr>
</tbody>
</table>
### Table 2: Type and focus of occupational interventions – training and education

<table>
<thead>
<tr>
<th>Training and education</th>
<th>Clubhouse work-ordered day – members attend the clubhouse as day care, but follow a structured routine designed to facilitate moving on to transitional employment (see below).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation/vocational training – clients are taught vocational skills and may gain qualifications. Projects are often located in colleges or training centres, or arrange workplace training.</td>
<td></td>
</tr>
<tr>
<td>Supported education – people with expertise in mental health issues advise and support people who wish to undertake training and education in inclusive settings (eg. mainstream college). Not widely recognised in UK as a coherent intervention approach.</td>
<td></td>
</tr>
<tr>
<td>Work placement and voluntary work – work in real settings but without pay or employment rights. Sometimes used while an individual's benefits are being assessed or while clients are gaining work experience and relevant workplace skills or building confidence.</td>
<td></td>
</tr>
</tbody>
</table>
### Table 3: Type and focus of occupational interventions – supported employment

| Supported employment | Workstep (known previously as supported employment [SE]) and Individual Placement and Support (IPS) – involve clients working in open employment with support from a job coach or other support staff. Clients are paid the going rate for the job, which can be full-time or part-time. In IPS, the provider is an integral member of the community mental health team.

**Supported Placement Scheme (SPS), Workstep and Personal Advisor Scheme (PAS)** – schemes for people with disabilities provided by the Department for Work and Pensions. The SPS scheme offered long-term support in the workplace; its successors after April 2001, Workstep and PAS, are time-limited, offering placement, some training, and support in open employment. This service is provided mainly by voluntary organisations and individual contractors, and is funded by the Department for Work and Pensions.

**Transitional employment** – time-limited exposure to open employment, with ‘ownership’ of job vested in a clubhouse, thus freeing service user from commitment to do work full-time. |
Further information, help and advice about opportunities

The Richmond Fellowship (www.richmondfellowship.org.uk/) provides support and advice on employment issues for people with mental health problems. This advice covers:

- employment advice to support individuals into paid work
- in-house work placements that develop work skills and self-confidence
- in-house training programmes, helping service users to further develop their skills and confidence.

The Richmond Fellowship is also developing a new service that will help people who have had mental health problems and are at risk of losing their job.

MINDFUL EMPLOYER™ (www.mindfulemployer.net/) is a national initiative led and supported by employers aimed at increasing awareness of mental health at work and providing support for businesses in recruiting and retaining staff.

The Sainsbury Centre for Mental Health (www.scmh.org.uk) aims to improve the life chances of people with mental health problems by improving the ability of services to respond to people’s needs, as well as tackling prejudice and promoting equality in society as a whole. Employment is a key focus of their work as they seek to develop and promote new ways of helping people with mental health problems get and keep work.

Stand to Reason (www.standtoreason.org.uk) is committed to fighting discrimination and stigma, challenging stereotypes and changing attitudes. It has a major focus on employment and mental health.
This section considers welfare benefits available to adults with mental health problems. This section aims to give advisers an overview of welfare benefit issues that clients with mental health problems may have to face in their attempts to re-enter the workplace. The information in this section is intended only to help advisers understand the complex benefits system. Advisers should not give their clients benefits advice; they should refer clients to benefits experts. This section covers:

- the context
- looking to the future
- inter-partnership working.

Context

In summary, although previous government reforms have contributed to an improvement in the performance of the UK labour market, unemployment levels are now rising to levels unseen for the last decade. In early 2009, unemployment stood at over two million. As the UK enters a recession, the topics of employment and mental health are set to become significant issues in the lives of many people.

A large number of adults with mental health problems are in receipt of benefits. In 2004, over 900,000 adults in England were claiming sickness and disability benefits for mental health problems. This group is larger than the total number of unemployed people claiming Jobseekers’ Allowance in England, and is estimated to cost the country £77 billion a year.

In the past, the welfare benefits system has been viewed as unnecessarily complicated, acting as an obstacle for individuals who can face numerous, interweaving barriers including issues related to housing and personal debt. According to the Office of National Statistics (2002), one in three people with serious mental health problems are in debt.

A significant disadvantage of the Incapacity Benefit (IB) structure has been that although it was designed to function as a safety net; many people became trapped in it, afraid to try out enterprise or self-employment for fear of losing their full entitlement to the appropriate level of support. The trends are important: after six months on IB, a person’s chances of going back to work are dramatically reduced; after two years on IB a person has only a five per cent chance of getting back to work. It is also worth noting that after a
prolonged episode of unemployment the likelihood of individuals actively evaluating their skills and career goals accurately is greatly reduced.

The longer they are out of the job market, the less likely they are to know what is expected of them as employees. In itself, this ‘not knowing’ may become an added source of anxiety that cannot be resolved while outside paid or voluntary employment. This lack of labour market mobility has had consequences for communities, families, individuals, society and the UK’s economic growth.

**Looking to the future**

The financial and social costs to the UK of such a large number of citizens being economically inactive have prompted considerable debate as to how this group, when appropriate, can be encouraged back to work. The underpinning philosophy is that paid work for most adults with mental health problems helps them fulfil their individual potential, raise their self-esteem and the future prospects of their family, as well as the nation’s skills base.

Under the old system, many benefit claimants attended work-focused interviews and undertook a ‘Personal Capability Assessment’. The interviews were a means of focusing claimants’ minds on work while acknowledging the other issues of concern, in order to create an opportunity to construct coping mechanisms within the context of the workplace. There were usually five interviews at four-week intervals.

In 2006, the government proposed changes to the Incapacity Benefit (IB) structure, which came into force on 27 October 2008. These changes apply to all new claimants, although existing claimants will continue receiving payments in line with the old structure until 2010, so long as they continue to satisfy the entitlement conditions.

The Employment and Support Allowance (ESA) has been designed to provide a more personalised service to help job seekers to access the support and skills they need to help themselves. The changes are not just designed to encourage people into work, but also provide them with the skills and support structures to keep them there. This new benefit is to be paid at two rates: a work-related activity component and a support component. The former is for those deemed able to move towards work, equipping them with the skills they need to re-enter the workplace; the latter is for individuals considered unable to participate in the labour market and provides them with the right support at the time they most need it.

When individuals first apply for the Employment and Support Allowance they will enter a 13-week assessment phase where they will receive a basic rate of benefit. During this phase they will be required to submit sick notes to their Jobcentre Plus and take part in a ‘work capability assessment’.

The government’s drive to reduce the number of people claiming long-term sickness benefits to 1.6 million by 2015 has also led to the reform of the NHS sick note. In keeping with the new updated welfare benefits system, which focuses on what a person can do, rather than what they cannot, the new electronic ‘fit card’ details what duties an individual can perform and suggests ways that responsibilities could be temporarily altered to take
Welfare benefits

into account their condition. The ‘fit card’ is due to be introduced in 2010 and although it has been supported by GPs, they have noted that it is important that medical practitioners are still able to advocate and support their patients, rather than ‘policing’ them.

The work capability assessment involves completing a questionnaire and attending a medical assessment to ascertain their level of disability. For claimants who have mental health issues, they may be asked to complete an additional questionnaire about the ways in which their condition affects them in terms of their mood, their behaviour and the way they relate to the world around them. If the assessment proves that an individual is facing significant health related issues, they will enter the second phase of the ESA from week 14 of their claim.

This group is then split into those who will be able to work eventually and those who will not. The former will receive a higher level of payment than would have been available through the previous system, but will be required to attend all work-focused interviews that Jobcentre Plus invites them to. The second group, those who are deemed to be severely limited, will also get a higher level of benefit but will not be expected to take part in any work-focused interviews unless they wish to. While the work-focused interviews are designed to help motivate and enable people back into work, it is important to note that if mental health issues have been the reason that claimants are no longer in employment, there may be a period of time when they don’t feel able to discuss their return to work, therefore the timing of the interviews needs to be handled sensitively.

The new benefit protocols aim to channel people to take control of their own working lives again, rather than supporting them to keep their heads just above water.

Inter-partnership working

It is a time of change with regard to the structuring of careers information advice and guidance. This is perhaps most notable in the emergence of the new adult advancement and careers service (aacs). Although this guide provides context and information relating to the immediate future, it is necessary for links to be made and maintained between information, advice and guidance practitioners and IBPA (Incacity Benefit Personal Advisers) from Jobcentre Plus. This will ensure that clients receive the most relevant and up-to-date information and practitioners feel confident working within current legislation.
This section contains three case studies: Jackie, Jane and John. Each gives indications of what works well for the practitioner and the client. While these case studies illustrate that many clients can move into work, learning and volunteering, it is worth bearing in mind that some clients will not be able to do this; for the adviser and client, it is not always ‘win-win’. This section gives you the opportunity to reflect on how you might approach similar situations to these three case studies. A copy of this is available to download in section 15 of this guide.

Jackie: in her own words

The background
In 2005 I became very ill with depression and by the time I saw my GP I was on the verge of a nervous breakdown. I was not eating or sleeping, was very anxious, and I had lost a stone in weight. I could see no future, no reason to go on, and I had to give my job up due to my illness. I had worked all my life, mainly in factory work, but I had the fear I would never work again.

My GP had a good chat with me and prescribed antidepressants. He also talked to me about an organisation that provided support to people in my situation. I was given a leaflet that explained how I could get help in finding another job, so I decided to give it a go. The worker was great. His role was to help me with a CV, job application forms and assorted paperwork. I went on some courses to help me manage my anxiety and lack of confidence. My worker even offered to take me to job interviews. ‘But who would want to employ me?’ I thought. I was over 50 years old, with no qualifications.

My worker was very approachable and supportive, and I was able to find another job, which seemed to go well to start with. My life seemed to be going well and I no longer needed support. Then, out of the blue, I received a letter in the post from my employers—ending my employment! I rang my old worker when I got the letter, and he was able to see me that day. I was devastated. In all my working life, I had never been sacked. The support team wrote a letter on my behalf to the area manager and I got a letter back to say I had been badly treated and she apologised on behalf of the company. But this meant I had no job again.
A happy outcome
I had always been interested in working with older people, and my adviser encouraged me to consider voluntary work. I was able to take up a voluntary post in July 2006, and I loved it. I could feel some of my confidence and self-esteem coming back. The more I did, the better I felt. I was climbing back out of that deep black hole. In September two jobs came up part-time in the service. I decided to apply. I did not really think I had much chance, but I had learnt a lot from my voluntary role. My interview went very well and I was offered one of the positions.

I have been a support worker now for eight months. I still cannot believe it. I love my job and I am honoured to wear my ID badge. I still have to pinch myself to see if it’s real. I love to get up in the morning to do my job. I am not the old Jackie, I am the new Jackie. I love life more than ever.

Jackie is a support worker for the Senior Steps Service (Building Blocks Solutions)

(Jackie wished to keep her own name as a positive example for individuals experiencing mental ill health and emotional distress.)

Points for reflection
Have you come across anyone like Jackie in your work?
If you had a client such as her what additional strategies could you have used?

...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
From the client’s point of view

Jane Smith

Jane’s background and situation
Jane had been out of work for some time before she made contact with a careers adviser. Her last role had been at a local nursing home, where she was employed for two years, before becoming physically unwell. In her early 40s, the impact of being off work had caused her to become unwell with both depression and anxiety, which had a major effect on her ability to integrate into the local community and socialise with others.

The barriers for her to move forward were:
- accessing the community due to low confidence and self-esteem
- a belief that she was no longer able to cope with the pressure of work and that, when she went out, everybody was looking at her and talking about her.

Jane and adviser: moving on
The local Jobcentre referred Jane to a community and voluntary organisation requesting support for her to explore possible options available for work in the area. Over a period of weeks, Jane and the adviser met and explored the following issues:
- trust between Jane and her adviser gradually emerged, enabling her to consider what she thought about herself, what she would like to do in the long-term, and what the barriers were to achieving this; however, anxiety remained that she would be forced into employment or risk losing her benefits
- options were considered, particularly those that would help her to gain self-confidence; uncertainty remained about whether she would be able to attend a course on her own; the adviser suggested Jane attend a confidence-building course with another person who lived locally, who was also due to start; Jane’s fears were allayed after meeting her fellow learner
- improvement was clear after several weeks, both in terms of confidence and motivation and her capacity to develop rapport and build friendships
- local learning opportunities were discussed with her adviser, to continue the positive improvement
- qualifications were required to enable Jane to pursue her chosen career in administration; she started an IT course and continued her weekly meetings with her adviser, either face-to-face or by telephone; checks were made on how she was coping and support was offered should she begin to struggle.

Progress had been made to a sufficient level after two months of engagement with her adviser. Jane decided to initially undertake voluntary work to prepare her for full-time or part-time work.

Supported by her adviser, Jane spoke to an appropriate voluntary organisation and visited the place where she would work.

Points for reflection
On talking with Jane for the first time, what might have been the focus of your discussions? Would your organisation have sufficient resources to arrange to see Jane several times over a period of several weeks? If not where would you refer Jane (or someone similar)?
From the client’s point of view

What worked well for Jane:
• her ability to see that, despite lots of difficulties, she was ready for a change
• Jane’s tenacity and emerging desire to engage with social and learning opportunities
• her ability to build a positive relationship of trust with her adviser.

What worked well for the adviser:
• building Jane’s confidence and trust over a long period of time; maintaining regular contact
• having a good overview of local opportunities, and supporting Jane to access these
• knowing Jane’s strengths and weaknesses and supporting accordingly
• joined-up thinking: ie. ensuring that Jane could access the course with another new student; keeping the support level right for Jane’s own pace.
From the client’s point of view

John Cripwell

John’s background and situation
John is a 35-year-old man who suffers from schizophrenia. He was first diagnosed at the age of 20, following his first admission to a psychiatric hospital. When John is unwell, he often experiences distressing auditory hallucinations, as well as a distorted view of reality, and as such has tried several medications and has been hospitalised on more than one occasion.

John now feels more confident; his current medication is proving successful and he believes that he has learnt how to manage his illness effectively. He is also less fearful of new situations. Although he still experiences anxiety, he feels ready for a new challenge.

A referral is made by his support worker for advice and guidance to enable him to look for suitable employment options, ideally part-time.

The barriers for him to move forward are:

- **bad experiences** of full-time employment prior to admission to hospital; a stressful environment led to John exhibiting increasingly bizarre behaviour; following his diagnosis, John did not feel well enough to consider paid employment
- **motivation** is difficult when he feels unwell; it is a challenge to perform even basic domestic tasks
- **anxiety** occurs if he is in a public place, even when he feels fairly well
- **fear of unwanted attention** – John recognises that sometimes his behaviour might be considered unconventional and fears that other people might ‘pick on him’
- **past actions** – John was once arrested for a minor shoplifting offence while unwell. He was treated very leniently by the court, but he is concerned that people will think he is dishonest and untrustworthy.

Points for reflection
Do you think that many advisers would think of John as a ‘schizophrenic’? If advisers commonly might do this, would it limit their ability to support John and similar clients?

In a first meeting or telephone encounter with John, what would be your priority (for example, listening, establishing a relationship, establishing the boundaries of support etc)? How might you best establish a rapport with John? Would your behaviour be affected by his mental health condition and his experience of offending?
John and adviser: moving on
The adviser contacted John to set up a meeting. John requested that this take place at his home, in surroundings in which he felt comfortable, and with his support worker present.

The meeting was concerned with **challenging and defining** the barriers John was encountering.

**Interest** was expressed by John in gardening and landscaping. John had gained experience of this after helping a friend.

**Outdoor work** was considered by John to hold more freedom. He didn’t like the idea of spending all day in an office, where he feared he would feel enclosed.

**Enrolling** on a horticultural course was discussed with his adviser, who informed him that one was available at the local college.

**Welfare benefits** – as the course was only one morning a week, it did not affect his benefits entitlement situation.

**Part-time work** was John’s goal; he hoped this would be possible if he did well on the course.

**Apprehension** was felt by John at the prospect of travelling the five mile journey from his home to the college, especially as he would have to use public transport.

**Preparation** – John and his adviser decided that it would be good groundwork to visit the training facility prior to taking part.
Action planning was critical, and a written action plan was constructed with John, describing the small first steps he was ready to take.

Outcomes
John attended an interview with the local disability employment adviser and he was assessed as suitable for the training package.

John was accepted onto a horticultural course run by his local college, which he attends part-time.

John still has regular support from his support worker – who also liaises regularly with the college on John’s behalf.

What the adviser found useful:
• relaxed and open body language, putting the client at ease; using John’s home and the objects with which he had chosen to furnish it as a conversational starting point allowed a discourse to ensue
• being patient and not expecting John to set unrealistic goals
• not making value judgments about John’s criminal conviction
• being supportive by accompanying John to interviews.

What John found useful:
• empathy and compassion were shown regarding the way that John’s schizophrenia had impacted on his confidence and anxiety levels
• help accessing public transport.
11 Continuing professional development (CPD) in mental health issues for advisers
Guide for advisers

This section of the guide suggests some professional development strategies for advisers. There is a considerable amount of change in attitudes to and knowledge of mental health issues. The field of mental health is a complex and fast developing area of medicine and related support. The government is keen to change attitudes and the legal framework that relates to adults with mental health problems. Given that, on average, a quarter of clients of careers and advice services will have experienced some mental health problem, advisers will need to keep up to date on the many aspects covered in this guide. This section covers:

- possible strategies for advisers
- an outline action plan for advisers.

Possible strategies for advisers

Advisers can:

- **develop a support system that is fit-for-purpose for their practice**
  
  To develop their own professional practice, advisers may wish to start by considering their own support network, and by working with their line manager to ascertain the best model for professional support and development. This can include examination of supervision methods and peer and mentor support, as well as time for analysis and reflection.

- **explore ways in which they can develop their skills and manage their emotions**
  
  Special training, mentoring, support from experts and experience over time are important elements for CPD. Two particular areas warrant the development of specific CPD strategies for advisers:
  
  - coping strategies for the ‘here and now’ when working with a client with a particularly challenging issue – for instance, self-harming
  - managing own feelings following a particularly harrowing client interaction.

- **use the CPD and mental health action plan**
  
  Using the outline plan below to map out development and training needs related to mental health issues may also be valuable. The companion Guide for Managers contains further information that will be useful in continuing professional development (CPD) in mental health issues.
### Table 4: CPD and mental health action plan for advisers

<table>
<thead>
<tr>
<th>Important issues</th>
<th>The specific issues which might be included</th>
<th>What do I need to prioritise in order to a) know more about b) be better able to do?</th>
<th>What do I need to do?</th>
<th>Timelines and urgency</th>
<th>Who else will I work with (including line manager, colleagues)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be positive about clients with mental health problems</td>
<td>What language do you use in relation to such clients? Why?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do you have a team or personal ‘promotional’ plan related to mental health issues in your area? If not, should one be developed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Become familiar with some of the common mental health conditions</td>
<td>What are the most common conditions that affect your client group?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What are the common symptoms associated with these?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Be familiar with legal and professional issues that apply to careers and advice practice with clients with mental health problems</td>
<td>DDA Confidentiality Disclosure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Continuing professional development for advisers

<table>
<thead>
<tr>
<th>Important issues</th>
<th>The specific issues which might be included</th>
<th>What do I need to prioritise in order to a) know more about b) be better able to do?</th>
<th>What do I need to do?</th>
<th>Timelines and urgency</th>
<th>Who else will I work with (including line manager, colleagues)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working with the client</td>
<td>Rapport Empowerment Privacy Boundaries of role Small steps for action planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work within the boundaries of the adviser role</td>
<td>Are you clear about the professional boundaries? If not, what do you need to do?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referring the client to others</td>
<td>List the agencies in your area that may be helpful with your clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Important issues

<table>
<thead>
<tr>
<th>The specific issues which might be included</th>
<th>What do I need to prioritise in order to a) know more about b) be better able to do?</th>
<th>What do I need to do?</th>
<th>Timelines and urgency</th>
<th>Who else will I work with (including line manager, colleagues)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of own strengths and weaknesses</td>
<td>Have you any misgivings about your work with clients with mental health problems? If so, list these and then classify them into 'rational misgivings' or 'irrational misgivings'. If uncertain whether rational or irrational, decide which categories you need to prioritise and how</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Which organisations can provide useful information and advice for advisers?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advisers should look after themselves</td>
<td>Reflect on what you need to do 'more of' and 'less of'</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Continuing professional development for advisers

<table>
<thead>
<tr>
<th>Important issues</th>
<th>The specific issues which might be included</th>
<th>What do I need to prioritise in order to a) know more about b) be better able to do?</th>
<th>What do I need to do?</th>
<th>Timelines and urgency</th>
<th>Who else will I work with (including line manager, colleagues)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of own organisation's policies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal support model</td>
<td>Have you got the best support model for your work within the boundaries of your organisation's remit?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The mental health field is awash with jargon and acronyms. This section gives the most common ones that may help advisers to support their clients. There are terms to describe specific mental health problems/illnesses, terms to describe treatments – including various medications – and terms to describe specific workers and services. Do not feel afraid to ask for an explanation of any term that you come across and don’t understand.

In this section, some of the more common terms are explained and spelled out.

**AMHP** – Approved Mental Health Professional – a social worker or other professional mental health worker who has been approved to carry out a variety of functions under the Mental Health Act 1983.

**Assertive outreach team** (sometimes called the AOT) – a team that works in a proactive way with people who have significant needs and are deemed to be ‘difficult to engage’ with services.

**AtW** – Access to Work, and **AtWAs** Access to Work advisers.

**BME** – black and minority ethnic.

**CAMHS** – Child and Adolescent Mental Health Services.

**CBT** – Cognitive Behavioural Therapy – a form of talking therapy that combines working to change a client’s thoughts (cognition) and what they do (behaviour).

**CMHT** – community mental health team – a multidisciplinary team of mental health workers that work with people outside of hospital.

**Co-morbidity** – a term that is used to indicate that someone has two or more diagnoses at the same time.

**CPA** – Care Programme Approach – the care planning system that is used for service users who are in contact with specialist mental health services and are considered to be in the greatest need.
**CPN** – community psychiatric nurse – psychiatric nurses are now officially called mental health nurses, but the old terminology of psychiatric nurse and CPN is still commonly used

**Crisis resolution team** (sometimes described as a home treatment team) – provides support to people in crisis, with the aim of preventing admission to hospital


**DEA** – Disability Employment Adviser – a specialist adviser who works at Jobcentre Plus

**Early intervention team** – a team that provides a service for young people with psychosis and their families

**Forensic services** – covers services for people with mental health problems who have committed offences and come into mental health services through the courts; includes services such as low and medium secure units and ‘special hospitals’, such as Broadmoor

**IAPT** – Improving Access to Psychological Therapies – a Department of Health initiative to make therapy and counselling (often CBT – see above) more widely available to people with mental health problems

**IBPA** – Incapacity Benefit Adviser – a specialist adviser who works at Jobcentre Plus (nb. these advisers are also known by other titles)

**IMHA** – Independent Mental Health Advocate – a trained advocate who is available to offer help to patients who are subject to the Mental Health Act 1983

**IPS** – Individual Placement and Support

**JIS** – Job Introduction Scheme

**Jobcentre Plus work psychologists** are a network of approximately 80 occupational psychologists who offer a range of local services aimed primarily at helping Jobcentre Plus disabled and disadvantaged customer groups progress into work

**LIT/LIG** – Local implementation team/group – the group that is charged with seeing that the NSF for Mental Health is implemented in their locality

**Mind** – The National Association for Mental Health – most localities have a local Mind association, some providing a wide array of services – [www.mind.org.uk](http://www.mind.org.uk)

**NDDP** – New Deal for Disabled People

**NSF (MH)** – National Service Framework for Mental Health

**NIMHE** – National Institute for Mental Health in England – set up in 2003 to take forward implementation of the NSF for Mental Health by providing guidance and support for local services
Glossary of terms and jargon buster

**OCD** – Obsessive compulsive disorder – described in section 1 of this guide

**PALS** – Patient Advice and Liaison Service – each NHS trust should have a PALS to provide initial information and advice to patients concerned about standards of their care and treatment

**PCT** – Primary care trust

**Primary care graduate workers** – employed since 2004 to help GPs manage their mental health workload by offering short courses of therapy

**PTSD** – Post-traumatic stress disorder – described in section 1 of this guide

**Rethink** – a national voluntary organisation for people with severe mental illness and their families – provides services through local branches – [www.rethink.org](http://www.rethink.org)

**STR worker** – support, time and recovery worker (sometimes called STAR workers) – a new type of worker introduced in 2004 to work with service users; they offer day-to-day support to service users to work with them towards their recovery
Listed below are useful books and websites for further reading on mental health problems.

British Psychological Society (BPS) (2004) *Understanding Mental Illness: Recent advances in understanding mental illness and psychotic experiences.* Contains a very useful summary of much of the key research in a readable form. Available to download at [www.understandingpsychosis.com](http://www.understandingpsychosis.com)

Chartered Institute of Personnel Development (CIPD) useful further reading on mental health at work is available from the CIPD website [http://www.cipd.co.uk/subjects/health/mentalhlth/mentalhlth.htm?IsSrchRes=1](http://www.cipd.co.uk/subjects/health/mentalhlth/mentalhlth.htm?IsSrchRes=1)

Department of Health website – for all documents related to current policy and legislation [www.doh.gov.uk](http://www.doh.gov.uk)

Disability Alliance has several useful publications [www.disabilityalliance.org](http://www.disabilityalliance.org)


Mental Health Foundation (2000) *Strategies for Living Update.* Summary of a report on user-led research into people's strategies for living with mental distress. Available to download from [www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)


Further reading and information

8221 9666; email: publications@mind.org.uk. Mind also has a large range of factsheets and booklets that can be downloaded from www.mind.org.uk

NIACE/NIMHE partnership project. A joint initiative between NIMHE and the National Institute for Adult and Continuing Education promoting access to education for people with mental health problems. See: http://www.niace.org.uk/mentalhealth/

NIACE. Various publications (some free and downloadable) on health, disability and education, available at www.niace.org.uk/mentalhealth/publications.htm


Sainsbury Centre for Mental Health. Various briefing papers covering all key policies and many crucial areas in mental health. Available to download from www.scmh.org.uk

SKILL: National Bureau for Students with Disabilities. This is a national charity promoting opportunities for young people and adults with any kind of impairment in post-16 education, training and employment. www.skill.org.uk


Mental Health Jargon and Acronym Buster. Compiled by Simon Heyes. Speak Up Somerset (2007). Available from Speak Up Somerset, PO Box 3484, Yeovil BA21 5ZH; tel: 01935 850 979; email: info@artofrecovery.com; web: www.artofrecovery.com
The development of this guide has been based on primary, unpublished research with advisers and clients in 2007. We have also talked with many experts, including those from the Career Development Centre, University of Derby, and TAEN, The Age and Employment Network. In addition, many publications have been examined. The specific references used are listed section by section below.

**Section 1**


**Section 2**


**Section 3**


Section 4


NIACE (2007) Moving Into Work: Supporting people with learning difficulties to make the transition from vocational education and training into employment. An information sheet for information, advice and guidance services including Connexions and Nextstep. Leicester: NIACE.

Section 5


Section 6


NACRO. Nacro is an independent voluntary organisation working to prevent crime. www.nacro.org.uk


Section 7


Section 8


NIACE (2007) Moving Into Work: Supporting people with learning difficulties to make the transition from vocational education and training into employment. An information sheet for information, advice and guidance services including Connexions and Nextstep. Leicester: NIACE.


Section 9


**Section 11**

**Section 12**