Inclusion in Work and Learning: Providing Information, Advice and Guidance to Adults in Acute Psychiatric Units

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Focusing on the inclusion of people with mental health disabilities

The Government's social inclusion agenda has a number of strands focused on mental health. These include the introduction of the National Service Framework for Mental Health (NSF) (DoH, 1999) which sets out the way modern mental health services will be delivered. It recognises that mental health services users, particularly those with complex and long-term needs, may require help with other aspects of their lives provided through a system of effective care co-ordination. The emphasis is on service-user involvement and the rights of people with mental health disabilities. The NSF specifically requires mental health services to combat discrimination and to promote social inclusion. Mental health services are being encouraged to move towards acting as catalysts for inter-agency and partnership working in order to promote inclusion and enable access for people with mental health disabilities to 'meaningful activities', including education and employment (DoH, 2002a, 2002b).

The Sainsbury Centre for Mental Health (2001), in a report commissioned by the National Service Framework Workforce Action Team, identified that mental health practitioners working with people with severe mental illness are facing a period of rapid change in provision. The Centre identifies a move away from focusing on hospitalisation towards the delivery of integrated community-based services involving multiple agencies - social services, housing, primary care, and the voluntary sector. The approach centres on user need and evidence-based interventions. Further, this report identifies the capabilities needed to implement the National Service Framework by mental health practitioners providing direct care services to adults. These include:

> 'A commitment to support and facilitate service users' opportunities to obtain meaningful and independent work where they can develop skills, receive an income and contribute to the community'

and also

> 'The ability to maximize user strengths and interests and increase their participation in meaningful community activities' (Sainsbury Centre for Mental Health, 2001, p21).

The Social Exclusion Unit (SEU) investigation into mental health and social exclusion is a second strand of the social inclusion agenda focusing on mental health. The SEU consultation document 'Mental Health & Social Exclusion' (2003) seeks to address the following questions:

1. What more can be done to enable more adults with mental health problems to enter and crucially, to retain work?
2. What more can be done to ensure that adults with mental health problems have the same opportunities for social participation and access to services as the general population?

The National Institute of Adult Continuing Education (NIACE, 2003) response suggests that recognition should be given to the key role that adult learning has in enabling people with mental health issues to engage in employment and social participation and that:

> '...sensitive and empathic guidance is needed as a first step into learning for many adults, particularly those with mental health needs. Guidance allows for individual needs, preferences and ambitions to be identified and for individual learning plans to be devised. Time invested in this process enables adults to successfully access appropriate learning' (NIACE, 2003).

The provision of an information, advice and guidance service that is able to offer guidance and support in relation to learning and work, to patients before and after they are discharged from acute psychiatric units, is therefore likely to be crucial to the effective implementation of a social inclusion mental health policy.

Social inclusion and recovery

There is also potential for professional guidance services to contribute to the recovery model which is coming to prominence in UK mental health services and is identified by the Sainsbury Centre for Mental Health (2002) as one of the factors that makes social inclusion a key policy and practice priority. The recovery movement emphasises the person living the life they have chosen in the community. It focuses on recovering what has been lost through mental illness and being a patient (Membrey, 1999). Knight (2000), cited in Allott *et al.* (2002, p6) defines recovery as 'a subjective experience

of having gained control over one's life'. The model is based on the premise that people can redefine themselves and move beyond their illness while still experiencing distress. Clients with serious mental illness are assisted to find their own meaning for their experience of mental distress; to find 'a way through', focusing on strengths rather than impairments in order to re-establish a sense of purpose and a role in society (Allott *et al.*, 2002). This approach involves the development of self-awareness; coping strategies, for example managing side effects of medication and symptoms; and professional and community support systems, rather than traditional rehabilitation programmes. Working for inclusion therefore involves the mental health services in acting as catalysts for community partnerships aimed at promoting inclusion.

Sayce (2000) maintains that this process of recovery is only feasible if opportunities for inclusion are developed and appropriate support is available. Recognising the active citizenship 'rights' of individuals is therefore central to enabling people with mental health issues who seek opportunities to actively participate in and contribute to society.

The philosophy underlying the recovery model has links with approaches taken by many career guidance professionals who work with adult clients in considering the multiple dimensions and interconnected aspects of their lives and how these influence their views of the future. Further, a systemic, holistic approach that engages the guidance practitioner in working not only with clients, but also in actively building bridges to local opportunity providers in education, employment and training has potential to contribute to the work of Community Mental Health Teams (CMHT) and other key support workers.

Opportunities for inclusion in work and learning

Adults with mental health disabilities are among the most marginalised and stigmatised by society. At any one time, 1 in 6 adults will experience some kind of mental health problem (Office for National Statistics, 2000) yet, although there appears to be some positive change in attitude towards mental health within workplaces (Warner, 2002), people with mental health issues continue to experience problems in accessing opportunities for entry into the labour market. Only 21% of adults who regard mental illness as their main disability are in employment – the lowest rate for any group with disabilities (Office for National Statistics, 2002).

Work is a means by which many individuals are connected to society and its values (Clark, 2002, Evans & Repper, 2000). It provides structure, purpose, access to social contact, a sense of identity and well-being. For many people with mental health problems it is also an important recovery and coping mechanism. In addition, participation in work activity can have long-term beneficial effects on clinical outcomes such as symptoms, medication compliance and relapse rates (Membrey, 1999).

Further, there is evidence that people with long-term mental health problems can work effectively given appropriate support and adjustments (Sayce, 2000). Bond *et al.* (1997), in a review of US studies of supported employment for people with severe mental illness, found that many studies showed that clients were able to sustain their employment, challenging the view that paid work is not a realistic goal. The effects of a particular mental health problem differ between individuals, therefore using a person's diagnosis as the sole determinant of their readiness to work is likely to be inaccurate (Ford, 2003). Membrey (1999) notes that very few studies have linked either diagnosis or severity of impairment with employment retention and there is a lack of evidence to support the assumption that efforts should be focused on enabling those with fewest symptoms to access work. The desire to work, interpersonal skills and work readiness are among the factors that are more significant in predicting success at work for people with severe mental health problems (Evans & Repper 2000).

Many of the benefits associated with employment are also experienced by mental health service users through volunteering, include improvements in health, stamina and confidence; feeling valued and supported; providing access to a social life and a reason for living (Clarke, 2003). It also provides an informal network for job searching and a 'stepping- stone' into employment for some volunteers with mental health issues.

Engaging in learning in its many forms, whether accessed through volunteering, formal or informal education, employment or training, has the potential to have positive effects on mental health and well-being. Those who experience mental health difficulties, however, often lack self-confidence and can feel isolated from the specialist support, advice and guidance they may need to access appropriate learning and career development opportunities.

Approaches to social inclusion

Many in the mental health field recognise the importance of promoting access to employment in order to advance social inclusion (Mind, 2002). Mental health services have responded in a variety of ways to the social inclusion agenda. For example, Lewisham and Guy's Mental Health Trust, cited in Sayce and Morris (1999), worked on the premise that, with appropriate support and training, employment for all can be an option. The Trust developed a partnership approach to providing service support dependent on need, which included building the capacity of non-mental health agencies to work with people with mental health problems and support them into learning and work.

Further, research by Butterworth and Dean (2000) has demonstrated the value of starting this process of accessing learning and work by clients with severe mental health problems during their time in the acute unit context. Their approach involved primary health care staff (as part of a Work Development Team) in providing vocational advice, with the option to refer to outside specialist learning and careers advisers. The findings indicate that patients benefit by seeing a reason for other ward activities and become ready for engaging in the process of learning on discharge. However, NIACE (James, 2001a) points to the potential difficulties associated with making contact with 'hard-to-reach' learners in healthcare settings where healthcare staff may be resistant to promoting learning as a vehicle to well-being and may lack knowledge, or have out-dated experience of adult, community or further education opportunities. The NIACE 'Prescriptions for Learning' service provided a Learning Adviser, seconded from the local Careers Service to GPs' surgeries. He worked closely with healthcare staff resulting in them referring patients to him for 'on-site' information, advice and guidance, which enabled many of these adults to move into learning (James, 2001b)

The Learning a Living Project

The Learning a Living project, funded in 2002/03 by Sussex Learning and Skills Council[1], aimed to combine the strengths of NIACE and Butterworth *et al.*'s approaches by piloting an information, advice and guidance service about learning and work within two acute psychiatric units. It employed a professionally qualified career guidance practitioner as a Learning Adviser who aimed to work in partnership with hospital staff to provide an on-site, independent and impartial service to patients. The Learning Adviser also set up post-discharge support into learning and work for those patients who requested it.

Method

The research aspect of the project comprised:

- Semi-structured pre-service interviews with 10 hospital staff working with acute unit patients to explore their perceptions of the support and help currently available to patients and their views about the proposed Learning a Living service. 8 of these staff also participated in a post-service evaluation.
- Questionnaires completed by 30 patients prior to the introduction of the service, which explored their experiences of work and learning; views of the future and of the services that they would find useful.
- A reflective journal compiled by the Learning Adviser throughout the lifetime of the project recording observations, critical reflections, insights gained and actions taken during the development and provision of the service.
- Researchers from User Q, a mental health user-led monitoring and evaluation group, conducted evaluation interviews with patients who had accessed the service. 16 service users were interviewed 2 weeks after their initial formal interview with the Learning Adviser and 11 participated in a second interview 4 months later.

Key findings, challenges and opportunities

A number of key findings emerged from the data collected through the course of the project. Commonly held views were expressed by hospital staff, service users and the Learning Adviser concerning various aspects of the service and suggestions were made to develop and improve the service:

Contributing to the recovery process

An aim of the Learning a Living service was to contribute to the recovery process by making available opportunities for patients to reflect on the past, consider the present and anticipate possible futures with the assistance of the Learning Adviser; and further, to enable patients to access learning and work by building bridges to local providers in the education, employment, community and voluntary sectors.

The recovery model differs from a medical model of mental health in its interpretation of the term 'recovery'. In the medical model, the notion of illness is central and recovery equates to 'getting better' or 'being cured'. This would imply delaying access to guidance until the patient was 'well' and able to benefit from it i.e. as close to discharge as possible. In contrast, the recovery model constructs the concept as a continuous process or journey of recovering meaningful lives through, for example, finding purpose, restoring hope, taking control, and experiencing success (Repper and Perkins, 2003). This model would imply making the service available to patients throughout their time in hospital as it might contribute to the recovery process itself, for example, by enabling patients to reflect on the place of learning or work in recovering their lives and to develop hope through planning and accessing activities of relevance, interest and importance to them both prior to and after discharge.

Patients with severe mental health issues were not found to be disinterested in the service or incapable of reflecting and planning with the Learning Adviser whilst in the acute unit. Some who participated in the evaluation reported that they had used their time in hospital to reflect upon their experiences and to consider their future:

1 Copies of the full report are available from Lewes District and Wealden Mind, 47 Western Road, Lewes, East Sussex, BN7 1RL.

'I had been thinking it over... I'm just reassessing my life. I'm coming to this point in my life when everyone is judging me. I'm at an apex. Now what shall I do? Otherwise I would be sitting in my flat creating electronic music or doing Photoshop on the computer'. (service user 1A)

Others referred to the effects of their episode of mental distress on their recovery before accessing the Learning a Living service which had acted as a source of hope and motivation, for example:

'I wasn't really thinking about doing anything because I had lost my will to live. You don't really think about starting up again' (service user 1B)

Planning for the future involved some service users in exploring with the Learning Adviser their work plans in the light of their current mental health. For example, one service user discussed recovery in terms of regaining control by avoiding pursuits in the future that had previously caused him to suffer undue stress:

'...I was doing a maintenance job...that was very stressful, because I'm not a tradesman at all and it was a nursing home...I ended up responsible for all sorts of things ...they'd call for "Jim'll fix it"...sounds silly now but it was quite stressful' (service user 1B)

Hospital staff also noted an improvement in confidence and motivation by patients who had used the service, with an increased interest in taking part in learning opportunities provided in the hospital. For example, one patient aimed to develop writing skills at a creative writing group in preparation for an essay-based mainstream course on discharge; others aimed to recover their concentration through activities such as gardening, as an initial step towards re-engaging with learning. Making a connection between learning activities available in hospital, and personal future goals identified with the Learning Adviser, may therefore provide a focus and purpose that encourages some patients to embark on developing specific skills in hospital or to gradually recover that which was lost.

Service users and hospital staff valued the introduction of this service. Hospital staff interviewed anticipated that it would provide a source of motivation and focus for patients; access to specialist knowledge, and contacts into learning and work that their own role could not accommodate. Most of the potential service users surveyed felt that specialist individual information, advice and guidance would be helpful at this time to enable them to consider their future. The evaluation by staff and patients supported these expectations and hopes in many respects. A number of service users interviewed had gained confidence:

'[The Learning Adviser] pointed me in the right direction straight away...I feel good about it...it has made me more positive' (service user 1A).

'...the meetings with [the Learning Adviser] has given me purpose...I'm just not the same person at all. A life altering experience...it gave me a huge boost in confidence' (service user 2A).

The evaluation study reported that the Learning Adviser was regarded as a source of motivation by most of the service users interviewed. They considered the advice and guidance to be appropriate and were implementing their personal action plan. A range of learning and work opportunities had been accessed including paid employment, mainstream education, training, voluntary work, a day centre and a sheltered workshop.

These findings mirror those reported in the NIACE project undertaken in GPs' surgeries:

'...the learning starts as soon as the client sees the learning adviser. Clients appreciated spending time with the learning adviser and reported feeling better for having been listened to and supported. They also felt more optimistic about their future as a result of talking about their concerns and discussing and developing possible options or learning opportunities.' (Slaney, 2001).

Accessing the Learning a Living service

It emerged early in the pilot on both acute units that the provision of publicity (through ward meetings, posters and fliers), together with access via a drop-in centre and/or through an appointments system, were insufficient. In response, the Learning Adviser introduced a more proactive approach, spending time on the wards in general conversation with patients about everyday matters and in taking part in shared activities. Patients who participated in the evaluation expressed a range of views concerning access. Some accessed the service after reading the literature, although most had wanted to identify or meet the Learning Adviser in order to decide whether to use it. Building in opportunities to engage with patients on an informal basis enabled the Learning Adviser to establish a level of trust, for example by addressing patients' commonly expressed concerns and suspicions about his role in relation to hospital staff and Government schemes.

The proactive approach resulted in a gradual increase in demand. A total of 56 patients engaged in one or more formal[2] interviews and 75 informal interviews were held during the lifetime of the service (available for 1 day a week for 6 months on one ward and 8 months on a second).

2 Formal interviews provided patients with the option of constructing a written personal action plan with the Learning Adviser, whereas the outcomes of the informal interviews were not recorded.

A professional, independent service

All staff and many service users interviewed identified the independence and impartiality of the Learning Adviser as a particular strength of the Learning a Living service. Staff felt it filled a gap in service provision. Prior to the introduction of the service, hospital ward staff described addressing patients' issues concerning future learning and work in a variety of ways. The provision of advice was reliant on the initiative of individual staff, who described this as giving general advice; making links with outside agencies; drawing on their limited knowledge of suitable opportunities to advise patients; and referring them to the CMHT or an assertive outreach team. Many expressed concern about lacking the time and resources to deal with issues beyond the immediate and practical when discharging patients. They felt ill-equipped professionally to provide specialist knowledge or contacts to opportunities in learning and work.

Staff also felt that some patients would not want to discuss their future with hospital staff who were in charge of their current care and treatment. They also regarded it as important that the Learning Adviser was not associated with the care and treatment of patients, yet worked with the staff team. The Learning Adviser sought to achieve this balance, which included communicating his professional independence to service users and enabled him to form relationships with patients on a different professional basis to hospital staff.

The perception of the service as independent of the provision of care and treatment by hospital staff has implications for whether the Learning a Living personal action plan should be incorporated into care planning. Including employment as a key aspect within every service user's care plan is suggested by Evans & Repper (2000) as a needed development. It would appear a logical next step for the Learning a Living personal action plan and discharge/care plan to be brought together to provide further coherence to the discharge process and support into the community for those who have access to a key worker. However, this study indicates that how this integration is managed may need to be carefully considered if the independence and impartiality of the Learning a Living service is to be maintained. It may be important to do this in a way that avoids patients acquiring the misperception, expressed by one service user in the evaluation, that participation in the Learning a Living service is a required element of the care planning process with which they should comply.

Continuity of support

The Learning Adviser worked to make and maintain contact with local opportunity providers and invested time in visiting schemes and in establishing referral processes. He also built links between key mental health workers and opportunity providers. For example, with the consent of individual patients, the Learning Adviser informed both a day hospital nurse and an opportunity provider of each other's involvement, which resulted in a more effective system of co-ordinated support to the patient.

Some patients reported that the service had responded to their needs for continued support; however, a need to ensure that continuity of the service for patients was sustained after their discharge from hospital was also expressed:

> *'I raised the issue of continuity and facilities were made to streamline the transition from careers advice to applying for work. I would like this continuity built in for everyone'* (patient service user 1D).

The Learning Adviser role therefore could be further extended to include facilitating the formation of effective links between practitioners who support patients with severe mental health issues on discharge and local opportunity providers. Increasing demand for the service could result in limits on the time available for the Learning Adviser to take on a substantive follow-up role. As such, it may be useful for the Learning Adviser to explore with individual patients sources of support, including CMHTs and key workers that they could access when implementing their personal action plan. The opportunity to review their plans for the future might also be anticipated and facilitated by providing links to Learning and Skills Council funded information, advice and guidance (IAG) services which they may access within the community.

Conclusions

If those with severe mental health problems are to move from the margins into the mainstream of society career guidance practitioners face challenges including developing services that are accessible and valued by patients, NHS mental health staff as well as opportunity providers.

The findings from this preliminary study indicate that an opportunity to reconsider the future, discuss aspirations, possibilities and steps forward, with an independent specialist guidance practitioner may make a positive contribution to the process of recovery, for example through providing a focus and purpose for some patients with severe mental health issues to re-engage with learning. The Learning a Living pilot further suggests that a proactive, informal approach by the adviser may be an effective means of developing understanding, trust and rapport with some patients who can then make informed decisions concerning accessing further aspects of the service. This requires a commitment to providing a non-discriminatory, client needs-based service in which sufficient time and resources are allocated to implementing a developmental approach to career guidance with this client group.

The introduction of changes in mental health service policy and provision through the National Service Framework (DoH, 1999) required a response by NHS Trusts that will actively address discrimination and promote the social inclusion of people with mental health problems. The challenge to develop a service that enables patients in acute psychiatric units to consider learning and work might be addressed by extending the range of specialist services with which NHS Trusts have traditionally worked. This could include inter-agency collaboration with those that are able to offer 'on-site', independent and impartial learning and career guidance, and who have direct links with employment and learning opportunity providers, including voluntary agencies, community groups, mainstream educational institutions and local training providers.

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