Supported Employment Teams: just for mental health?

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Introduction

Recent years have seen UK mental health services pay more attention to waged open employment and this has led to a corresponding increase in the numbers of employment specialists. There are a variety of opinions about whether such specialists should be dispersed in multidisciplinary teams, gathered into a specialist team, or integrated with colleagues who specialise in employment for people with learning or physical disabilities.

This paper offers a framework for reviewing the benefits of each option. Many of the issues that arise will be of interest to agencies that provide services and their managers, as well as to commissioners, particularly as procurement arrangements are being changed by the Coalition government.

Policy Context

Research in 2003 identified that around 70% of people using mental health services would like a better level of support and more help in returning to paid employment[1].

In 2006, the Government repeated its wish to reduce the segregation between people with different categories of need[2]. In the same year, it was recommended that a specialist vocational lead be identified in each community mental health team to blend clinical and vocational support, along with the creation of employment forums to improve local coordination.

Meanwhile, specialist health care continues to be organised by diagnosis and separate guidance documents on employment have been issued for learning disability and for mental health services[3].

Polarity Maps

We are interested in finding out how local services manage the competing pulls to locate employment specialists in mental health teams and capture the advantages of collaboration between vocational specialists in mental health

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[1] Thomas, T, Ryan, T, Newbigging, K, (2003) *SEU consultation exercise. Mental health, illness and social exclusion* Health and Social Care Advisory Service. http://www.sesami.org.uk/commissioning-guidance.pdf accessed 20/08/07

[2] Department of Health (20005) *Independence, Well-being and Choice.*

[3] HM Government (2009) *Working our way to better mental health: A framework for action* Cm 7756. Also Department of Health (2009) *Valuing employment now - real jobs for people with learning disabilities.*

and with those colleagues who provide employment support to other social care groups.

Some areas resolve the issues with a hybrid approach. For example, some local authorities have created a series of small pan-disability services, each serving its local neighbourhood and where individual team members carry a lead role for a specific social care group and liaise closely with the relevant team.

Thus there are three broad options to consider:

1. to locate workers in a Clinical Team or a Vocational Team;
2. to operate with small teams or a large team; and
3. to link vocational workers in a single disability team or a pan disability team.

The following sections highlight the complex interplay of these issues, and the wealth of factors that need to be taken into account when such changes are made. This leads on to an exploration of actions that might bolster the strengths and overcome the weaknesses of each option.

For each section, we have summarised the upside and the downside of each option. Items that could be repeated in several boxes with little variation (for example, a small team has proportionately high management costs, whilst a large team might achieve economies of scale) are placed in one box only in order to save space. Readers may therefore wish to reflect on the relevance of all the items to their current or proposed service.

Barry Johnson[4] names these tables as *polarity maps.* A polarity map can describe a problem that has no solution but can only be managed on a day-to-day basis, such as the problem of how to balance individual and group goals in a staff team.

To use a polarity map, we must first understand all four quadrants – the upside and the downside of each option. Johnson explains that this is more challenging than it appears, as most of us favour one of the diagonals and tend to 'grey out' the alternative viewpoint. For example, if we are driven by personal success, then we will tend to see the upside of individual goals and the downside of team goals, while a more team-oriented person will find it easy to list the upside of team goals and similarly easy to list the problems associated with individual goals.

Once we have created the polarity map, then we can decide which of the upside options to use as a starting point for our organisation. Because the polarity is constantly present, ever changing, and cannot simply be designed out of the organisation, then constant vigilance is required. In our example of individual and team goals in a staff team, the manager may decide to focus on

[4] Johnson, Barry (1992) Polarity Management: Identifying and Managing Unsolvable Problems. Amherst, Massachusetts: HRD Press, Inc.

team goals, but the personal goals for individual team members will intrude from time to time.

So the effective polarity manager will decide their upside option, and then look both *across* and *down.* Looking down will identify the problems that accompany the option that has been chosen, and it may be possible to design safeguards and defences that retain the upside benefits whilst avoiding the downside problems of this option. Then, simply by choosing this option, one has forgone the alternative, and therefore missed out on the potential benefits that would have accrued with it. By looking across at these benefits, it may be possible to identify some ways to include these factors in the option that has been chosen.

If the manager fails to actively manage the polarity, and particularly fails to look down and across, then the system will slip into an infinity loop. Johnson shows how, after choosing the upside of one option, the weaknesses of that option quickly appear. From the new position in the lower half of the diagram, the diagonal look appeals, and so the system is reorganised to gain the upside of the other option. Soon after reorganisation, the weaknesses of the new arrangement appear, the organisation slips into the lower half of the diagram and looks across the new diagonal. The cycle is complete.

We believe that Johnson's model is helpful in thinking about how employment services are arranged, as each of the three big questions outlined earlier are polarities. Whatever the organisational arrangements, the employment specialist will have to relate to clinical and vocational services, to operate within a small or large staff team, and to interact with employment specialists working with other care groups. These issues will not go away, and so it is worth drawing the polarity maps.

There are, of course, elements that affect the quality of the service irrespective of the organisational arrangements. A relentless commitment to the task of assisting people to get the career they want, effective commissioning and leadership and persistent attention to quality monitoring and outcomes will create success in any environment while chronic uncertainty, focusing on problems and blaming others will cause damage everywhere.

Polarity Map 1: Clinical or Vocational Team.

The Government has indicated that Vocational Specialists working in mental health services need to be members of the Clinical Team, but also that they need to act 'as a unit' rather than as isolated practitioners. This creates a clear example of a polarity, as effective, holistic support blends clinical and vocational input, but the organisational options (where is the worker based, how much time is spent in meetings and with whom, who line manages the individual practitioner and where does strategic leadership come from) might indicate that one pole is favoured over the other. The following table explores the impact on the vocational service, on the assumption that the clinical team

is effective. If this is not the case, then this will substantially affect the vocational work.

Clinical Team	Vocational Team
Vocational specialists in the clinical team – possible advantages • *Easy to obtain a psychiatric opinion if the person becomes acutely ill* • *Vocational and clinical input can be easily coordinated in a timely fashion* • *Vocational focus, optimism and skills may rub off on clinical staff, lifting their skills* • *Strong relationships can mean vocational specialists get invited to care planning meetings*	**Vocational specialists in a vocational team –possible advantages** • *Ring fences staff time for vocational work and can coordinate to connect with the full range of employment sectors and agencies* • *Maintains a focus on and optimistic approach to employment based on the social model of disability* • *Differentiation of skills, employment sectors and client groups can be achieved, improving service quality* • *Can serve people who need vocational support but do not fit neatly into the clinical team's eligibility criteria or who need a clear non-medical response*
Vocational specialists in the clinical team – possible disadvantages • *Vocational staff may be diverted to crisis response and other activities* • *Distinctive approach may be lost as out-stationed workers 'go native'* • *Continuing professional development of vocational workers may be lost as lone workers are always more skilled than their clinical peers, rather than stretched by vocational colleagues* • *Seeing the employee at work may drift into discussions of health issues, thus teaching employee and employer that it is acceptable to discuss these things at work – and this may reduce employability and suggest jobs are offered as part of welfare rather than as a business contract.*	**Vocational specialists in a vocational team – possible disadvantages** • *Can generate negative stereotypes between clinical and vocational teams* • *Other teams may abdicate responsibility for vocational matters* • *May be unskilled in mental health issues and so place people in risky situations* • *Outcome monitoring (with fewer, more or different targets) may reinforce a feeling of distance from the clinical team*

Polarity Map 2: Small or large team

Hard-pressed health and social care services can find it difficult to dedicate resources for employment and so vocational specialists can find themselves either as lone workers or working in very small teams. Before moving on to the implications of merging client groups to form a pan-disability team, we need to consider the advantages and disadvantages of large teams compared to small teams.

Small Team	**Large Team**
Possible advantages of a small team • *Individual creativity can thrive as the team is less focused on compliance with bureaucratic systems* • *Having several small organisations may facilitate competitive innovation and creativity* • *Ring-fenced and targeted work and expertise with specific people*	**Possible advantages of a large team** • *Possible to segment the markets (employers, referral agencies, the community, policy, innovation), employ a representative workforce and increase expertise and frequency of personal contact* • *There is potential for workers to vary their job role or be promoted within the team, thus reducing staff turnover* • *A larger team may have more time to undertake development work or create a balanced workload thus increasing job satisfaction and reducing job stress*
Possible disadvantages of a small team • *Vulnerable to cuts as all funding may come from one place and there may be less fuss about closing services* • *Less flexibility to provide a choice of worker to jobseekers or absence cover to colleagues* • *Duplication of management functions across teams and large employers may be bombarded with unco-ordinated requests*	**Possible disadvantages of a large team** • *The team could create its own separate cultural identity, become inward looking and distanced from the clinical teams* • *If this team loses heart, funding or skills or becomes dysfunctional then everyone suffers* • *The team may drift away from serving hard-to-place groups*

Polarity Map 3: Serving a single or multiple care groups

Serving a single care group	Serving multiple care groups
Possible advantages of serving a single care group • *Strong connections may be formed with health and social care agencies as each contact reinforces links with the same team* • *Colleagues who substitute during absence likely to know about the person's needs* • *More likely to work with people with complex needs, rather than just those who are 'close to the job market'* • *Develops the knowledge base of how to adapt approaches so they are specific to disability type.*	**Possible advantages of serving multiple care groups** • *Coordinate contact with employers and funding sources. Focus on success and the contribution of employees rather than disability.* • *Aligns with mainstream society and the legislative frameworks affecting employers, Job Centre Plus and regeneration services that tend not to differentiate care groups* • *Needing to learn about different support needs promotes inquiring attitude and more skills. Wider pool of expertise within the team for individual staff to draw upon.* • *Can encourage employers to employ or train in-house staff as coaches and mentors, since the focus is on job support rather than the impairment*
Possible disadvantages of serving a single care group • *Poor support for jobseekers and employers with overlapping needs or outside eligibility criteria* • *Yet another disability-specific service reinforces label. Leaving people in their 'disability category' groups wastes an opportunity to challenge those who resist being associated with other disability categories.* • *A team working with an especially hard to place group may become discouraged without the quick wins that are sometimes achieved when working with a more diverse group* • *A team that works with people who have a negative reputation may experience more discrimination*	**Possible disadvantages of serving multiple care groups** • *Project may be seen as no-one's responsibility and so elude funding opportunities* • *Staff need more and broader training and may lack expertise (or be perceived to lack expertise) in serving people with complex needs* • *Staff transferring in from single client-group services may feel uncomfortable, leave or resist working with non-preferred clients. They may assume that what worked for one person will work for others.* • *Blending several services and funding sources may result in differences in pay and conditions of work, ways of working or contradictory eligibility criteria and outcome monitoring systems.*

The way forward

The following suggestions are largely drawn from the three polarity maps set out above, but we may have slipped in a few lessons we have learned from elsewhere.

Designing the service

- Consider all the factors in these polarity maps before deciding how to organise your service. Find ways of:
    - capitalising on the advantages that come with the option you have chosen
    - minimising the disadvantages that come with the option you have chosen
    - building in the advantages that would have come to you if you had chosen the alternative option.
- Design a service that results in staff having frequent personal contact with the same people (those using the service, employers and colleagues in health and social care agencies). This is because effective employment work relies on close relationships (as well as an ability to 'cold-call' strangers) and close relationships form the best opportunity to combat discrimination.
- Utilise competitiveness, cooperation and affirmation to develop a creative, problem-solving culture.
- Seek a broad, long-term funding base and then target these scarce resources whilst addressing the needs of people who are hard to categorise.
- Use stringent outcome monitoring to capture information on success and analyse it to find out what is working. Collect stories as well as numbers.
- Ask individual team members to specialise in specific segments of the referral group, employment market, interventions or policy issues.
- Be clear that the message to employers is that the service exists to help them deliver their business outcomes more effectively by helping them recruit and retain good staff rather than 'please help these disabled people by giving them a job'.

Team culture

- Keep the big picture in mind, that this is all about creating a fair society of opportunities for everyone to have a good life.
- Find ways to test the team climate – is it hopeful, optimistic and positive about risk-taking rather than pessimistic and risk averse? Talk about these things and devise ways to repair problems early. If the team is dysfunctional, address the issues, rather than assuming that restructuring will fix anything.
- Promote continuous professional development for staff and a learning culture in the team. The job title, team name or even last year's experiences are no substitute for today's learning.

Working with people using the service

- Avoid assumptions that people with different labels are different from each other or from the general public, and that people with the same label are all alike.
- Combat role engulfment (seeing oneself as no more than a patient or 'service user') by emphasising people's roles as jobseeker and employee.
- Think about how to focus on people in greatest need of support whilst achieving some 'quick wins' that will encourage the team.

Working with employers and intermediaries

- Coordinate contact with employers and intermediaries such as JobCentre Plus.
- Work with the reality that some disability labels attract more negative attitudes than others.
- Focus on creating accepting workplaces rather than diagnosis or difference.

Working with others

- Join hands with other services to share research and good practice and to coordinate awareness-raising work.
- Use the commissioning process to regularise staff roles, term and conditions, eligibility criteria and operational and monitoring systems.

Conclusion

There is clearly no magic solution to the question of how to balance proximity to clinicians, targeted vocational expertise, and wider coordination of vocational support.

Rather than worrying too much about which option to choose, it seems to us that teams would do well to check the contents of the summary boxes and ensure that they have the mechanisms in place to reinforce the strengths and minimise the weaknesses of their chosen option.

Moreover, since solutions that were perfectly effective in the past may have lost some of their efficacy, some open-minded consideration of current needs and responses can also help to keep projects sharp and relevant.

Finally, we return to the basics. However the service is configured, it needs to be commissioned, led, personalised, skilled, developed and evaluated. As people increasingly choose what support to buy, then vocational services, like all others, need to be clear about their role, relationships and outcomes.