

DWP Commissioning Strategy – interim report

A response from the Sainsbury Centre for Mental Health

We welcome the opportunity to comment on this important document. The Sainsbury Centre for Mental Health (SCMH) is the leading, independent think tank concerned with work and employment opportunities for people with mental health problems who constitute more than 2 out of every 5 people on Incapacity Benefit. Their movement out of the benefits system does not seem to be improving at the same rate as it is for other groups and we believe that this reflects a poorer understanding of their needs and the most effective ways to help them.

In the psychiatric rehabilitation literature there is now a strong evidence base on what works to support people with mental health problems to access and remain in employment¹. These data particularly highlight the success of 'place-then-train' models. The data also suggest *inter alia* that it is the characteristics of service programmes that have a much greater impact on employment outcomes than individual client characteristics such as diagnosis, level of functioning, age, gender, etc. It is therefore particularly important that both commissioners and service providers have the knowledge, skills and competencies to design and deliver effective services for these groups of clients.

Our comments are underpinned by this evidence base and our expertise informs both commissioner and provider perspectives. As most of the experience in the delivery of employment services for this group resides in smaller specialist organisations, our comments here are particularly focussed on the interface between 'top-tier providers' and the smaller, more local, specialist providers.

1. Commissioning effective work and employment contracts for people with mental health problems

The evidence suggests very strongly that *jointly commissioned* contracts ('joint' between vocational and health agencies) are most helpful for developing effective provision². To achieve successful outcomes and make more effective use of resources, the DWP commissioning strategy therefore needs to place strong emphasis on joint commissioning, where possible within the framework of the new Public Service Agreement target on mental health and employment³. The PSAs provide DWP with the opportunity to work with Health and Social Care commissioners to dovetail objectives and agree joint targets, with clear accountabilities and integrated delivery across local populations. We would be very concerned if this key element of effective commissioning practice were not to be given due prominence in the strategy.

¹ Boardman, J., Grove, B., Perkins, R. & Shepherd, G. (2003) Work and employment for people with psychiatric disabilities, *British Journal of Psychiatry*, **182**, 467-468.

² Department of Work and Pensions/Department of Health/CSIP (2006) *Vocational Services for People with Severe Mental Health Problems: Commissioning Guidance*. www.dh.gov.uk/mentalhealth

³ **PSA Delivery Agreement 16**: *Increase the proportion of socially excluded adults in settled accommodation and employment, education or training*: National level indicator – the proportion of adults in contact with secondary mental health services in employment.

2. Relationships with prime contractors

We remain concerned that the payment by results funding structure will give the lead contractors a perverse incentive to exclude groups that are difficult to place and to save costs by awarding sub-contracts that are financially unviable for smaller, specialist organisations. Our considered view is that DWP has a responsibility not only to monitor outcomes achieved with groups who have specific needs (e.g. mentally ill) but also to set targets to ensure equality of access (see below). Furthermore, DWP has a responsibility to monitor the relationships between lead contractors and their sub-contractors and to take account of these processes when renewing contracts.

3. Placement of sub-contracts with local specialist providers

In setting the criteria for appointment of sub contractors, we would also recommend that attention is given to the organisation's track record in working with people with mental health problems. This is of particular concern when these are associated with drug and alcohol problems ('co-morbidity' in mental health is a common issue). If DWP is to achieve its goal of working with '*every customer*', it must ensure that sub-contractors are not only capable, but also confident and optimistic about achieving success with this client group. This latter point is crucial as the evidence demonstrates very clearly that communicating a belief to the customer in the possibility of successful outcomes is more than half the battle in achieving a positive outcome. It is also our view that special financial provision (eg. graduated payments) should be made for 'hard to place' groups which take account of the additional time that may be needed for them to find and settle into work. . Our intelligence is that such a system works well in parts of Australia.

4. Ensuring access

As indicated above, people with mental health problems are unpopular with many generic provider organisations because they are perceived to be a 'bad bet' in terms of their success rates for placement or maintenance in paid employment. We would therefore suggest that the contracts must include entry criteria that specifically stipulate a proportion of people with enduring mental health problems and associated difficulties. (For example, Local Area Agreements could specify that 50% of referrals must come from specialist mental health service providers, i.e. NHS and Foundation Trusts). Similar selection criteria must be utilised if other 'excluded groups' such as ethnic minorities, offenders, or people with primary substance misuse problems are also to be targeted. One of our key concerns is that a preoccupation with 'results' in terms of employment outcomes, although fine in principle, will lead providers to 'cherry pick' those clients who they think will have the best outcomes. This must be guarded against.

5. 'Case management'

We generally support the concept of 'case managers' tasked to develop comprehensive, individually-centred, packages of care. However, we would point out that the research on the effectiveness of case management in mental health services suggests that it will not work unless: (a) case managers combine an element of *service delivery* in addition to their role as assessors (i.e. do not use a simple 'brokerage' ('signposting') model); and (b) that

they provide some continuity of care, through the steps of assessment, placement and ongoing support to both the employee and employer. From the perspective of mental health 'customers', this continuity of support is one of the key ingredients for success.

6. Performance managing quality and effectiveness

We believe strongly that there should not be a "black box" approach in relation to performance management of contractors whereby they can do what they like as long as they achieve results. This deliberate turning of a blind eye to methods and quality standards can lead to ineffective – and in some cases - damaging practice. (The interventions are not without a capacity to do harm in terms of adding to peoples' employment problems, rather than reducing them). The criteria for performance must therefore include a set of 'evidence-based' standards for effective and ethical practice. Being '*tough on providers*' is all very well, but will be ineffective in improving their performance unless the specification is not only clear about outcomes, but also about how these are to be achieved.

7. Job Placement

In terms of successfully returning people with mental health problems to work, the performance standards must be based on the specification of quality indicators provided in the 'Individual Placement and Support' (IPS) fidelity scale⁴. Unless providers are required to conform to these criteria – paid employment focus, consistent with customer preferences, rapid job search, vocational and health interventions integrated, etc. – they will not achieve good outcomes and may actually damage the health and life chances of their customers.

8. Job Retention

A similar set of quality indicators must be developed regarding job retention services. These have not yet been subject to the same kind of rigorous analysis as the job placement models, but there are some examples of good practice to draw upon (e.g. Avon Job Retention Pilot⁵, Richmond Fellowship's 'Retain' model⁶, and 'Health@Work'⁷). These suggest some common features for success – job specialists based in primary care, good integration with health interventions particularly psychological therapies, direct support for employers in the workplace, flexible follow-up, time as required (etc.). As above, contracts should specify these quality effectiveness indicators. SCMH would be happy to advise further in this area.

9. Monitoring of outcomes – 'value added'

In terms of the monitoring of outcomes, we believe that two principles are important. Firstly, outcomes must be measured against 'inputs' (i.e. in terms of 'value added'). This

⁴ Becker, D.R., Drake, et al. (2001) Implementing Supported Employment as an Evidence-Based Practice. *Psychiatric Services*. 52, 313-322.

⁵ [www.scmh.org.uk/80256FBD004F3555/vWeb/fIKHAL6MRJTQ/\\$file/nehin+mh+and+job+retention.ppt](http://www.scmh.org.uk/80256FBD004F3555/vWeb/fIKHAL6MRJTQ/$file/nehin+mh+and+job+retention.ppt)

⁶ www.cambridge.gov.uk/ccm/cms-service/download/asset/?asset_id=8702035

⁷ www.healthatworkcentre.org.uk

means that all contractors must collect key information that describe the populations served in terms of potential predictive background information (e.g. recency of paid employment, length of longest job, etc.). This will also help to avoid 'cherry picking' and 'parking'. [N.B. As indicated earlier, traditional health criteria like 'diagnoses' do not predict outcomes].

10. Monitoring of outcomes – a broader view.

Secondly, with mental health populations it is useful to take a slightly broader view of outcome than simply placement in open employment. Thus, placement in mainstream education or training, volunteering, etc. may all be important outcomes for people with mental health problems, as permanent or temporary solutions to long-term unemployment. Stability of outcome is also important, therefore longer follow-up is necessary. This approach to outcome measurement is well-illustrated in Rinaldi & Perkins (2007)⁸. Shared information systems would clearly facilitate such an approach.

We hope that these comments are useful and would be happy to discuss further if you required. We would be particularly interested in having an input to developing the Capabilities Framework and the Code of Conduct, both of which have been identified as key next steps in this process.⁹

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The Sainsbury Centre for Mental Health is an independent organisation, funded by the Gatsby Foundation, which has for more than 20 years been dedicated to improving the lives of people with mental health problems through research, policy work and service development. It has two main programmes – Employment and Mental Health and Criminal Justice and Mental Health. For further information see www.scmh.org.uk or email jenni.bacon@scmh.org.uk

⁸ Rinaldi, M., & Perkins, R. (2007) Implementing evidence-based supported employment. *Psychiatric Bulletin*, 31, 244-249.

⁹ Commissioning Strategy interim report findings. Alan Cave, DWP Delivery Directorate Director. 16 January 2008.