

Providing effective job retention services for people with mental health difficulties

Principles and Practice

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Background

In 1996, we conducted a survey with people having vocational needs at Barrow Gurney Psychiatric Hospital, Bristol. One of the issues highlighted through the survey was the lack of a coherent strategy to help people get back to work. 78% of those interviewed had lost their jobs after becoming ill. Shortly after, an approach, based on the author's previous experience of helping people back to work, was established in Bristol. This intervention was called '**key stages in job retention**'. It provided a useful checklist for the Occupational Therapists in the Trust to address this employment issue. Ultimately, the developers were asked to run a small national pilot resourced by the Department for Work and Pensions (DWP) and by the National Health Services (NHS) Executive. This pilot was evaluated by King's College, London. In order to effectively measure the case management approaches adopted in the Pilot, a Literature Search was undertaken.

Since this time, the author, together with Dave Costello, has conducted training in job retention case management skills for organisations and health trusts throughout the U.K.

Armed with this knowledge and in consultation with colleagues around the country, it is time now to set down the guiding principles and practice that govern good job retention services.

Principle 1: Early Intervention dramatically improves the possibility of people returning to work.

By the time individuals get to secondary mental health services, only a small proportion is still in work (15-20%). Recognizing that people with mental health issues need support in retaining their jobs, it is essential that services move 'up stream', developing strong partnerships with General Practitioners and with the Primary Care Trust. Evidence shows that intervention within the first 6 weeks of an employee being off sick can be crucial. After 6 months of sickness absence the chances of returning to work are only 50% and after a year only 25%.

Also important is the development of good relationships and support mechanisms with local employers. This creates the potential for establishing earlier interventions through employers' Human Resource Departments, Occupational Health and / or Line Managers. Through this referral route, employees who are still working, but displaying symptoms of mental distress, can receive help in a timely fashion.

Principle 2: Case Managers are effective in assuming some burden of responsibility during the process.

Listing the number of agencies and individuals potentially involved in a job retention case, it is difficult to imagine how a person successfully returns to work without the support of a Case Manager. People can make precipitous decisions, like resigning because they feel 'they have let the side down'. They can enter into conflict situations with Line Managers and work colleagues. They can 'fall out' with their spouses who are trying to help but who have limited expertise. Working with a Case Manager, the client can cope with these issues in a more positive fashion.

The client writes to all stakeholders based on a contact map announcing that the Case Manager is acting on their behalf and that all queries regarding their employment should be directed to the Case Manager during the recovery process. Stakeholders might include but are not limited to Occupational Health, Human Resource Department, Line Manager, Trade Union Representative, and the General Practitioner. The client also gives permission for confidential information to be released to the Case Manager.

Principle 3: Assessments are essential in providing a complete picture of the clients' life at the time of referral.

Assessments need to be holistic and need to take into account the client's physical as well as psychiatric health, their social and economic circumstances as well as their vocational profile. There can be a tendency in the culture of health services to assess the mental health symptoms of the client only. Other factors, like interests, aptitudes and skills, are referenced but it is rare that they are paid the same attention. This is particularly true in Primary Care where, with limited

resources, it is difficult to act on potential assessment findings. The assessment then becomes a waste of time!

With effective job retention work, it is important to assess not only the client but their work environment as well. This would involve gaining an accurate appreciation of the client's job role and demands, and identifying any specific job stressors or precipitating events in the workplace that may have led to psychological injury.

Initial assessment with the employee should not be a form filling exercise but should be seen as a real opportunity for the client to 'tell their story', freely and without blame or prejudice. It is often best for G.P.s. to delay 'prescription' till after the assessment process is completed.

Initial assessment is simply the start of the process. On-going assessment is essential. The re-evaluation of 'back-to-work plans' is necessary if failure is to be avoided. Without a case management approach, it is unlikely that co-ordinated action can follow assessment.

Principle 4: A collaborative individual planning process provides a vital foundation for effective service delivery.

The key to effective 'back-to-work planning' is the pivotal role of the client in goal setting and in plan development. After the trauma of mental illness, it is essential that an empowering process take place. This will only occur in the world of 'can'.

Illness has placed the client in a world full of what they can't do. This leaves them helpless, impotent, and with a chronic sense of failure. The recovery journey must begin from a place of strength, however limited that place may seem to be. Key questions are: What parts of my work do I enjoy? Who are my friends and allies at work? What out-of-work activity do I enjoy? What do I value in my marriage/partnership/friendships? Having established this base camp, it is possible to climb 'the mountain' of recovery and to start mending the parts of life that have become dysfunctional.

Given that (lack of) *control* and (excessive) *demands* have been identified as two crucial factors in job stress, it is vital that the client is able to regain a sense of control over their situation. They therefore need to be fully consulted throughout the case management process, which needs to be made as transparent as possible.

Principle 5: Mental health is all about relationships and supporting the naturally occurring support.

The relationship between the Case Manager and client is, in itself, a powerful tool for recovery. A trusting relationship is essential; nothing else can happen without it. Evidence for hope must be gathered. The focus should be on solutions, not on problems.

The Case Manager also offers support to and encourages support for the client from a trusted workmate, a spouse or a friend to ensure that there are several support sources available. The work mate, for instance can be the client's ambassador when the client returns to the workplace. They can be an intermediary with colleagues, helping to demystify and de-stigmatise mental illness. Having a work ally can be particularly powerful if social contact is made prior to return to work. This helps to prepare the ground. The Case Manager should meet with the client's natural supporters to ensure that they reinforce client coping skills and identify and inform the Case Manager of triggers to relapse.

The client may have gone through a period of social isolation during their illness and may well need the help of the Case Manager to rebuild relationships. Again solutions based approaches should be used. Case Manager support should not be arbitrarily withdrawn but rather gradually phased out; from meeting weekly at first, then fortnightly, then monthly and then offering periodic support via the telephone.

A 'discharge mentality' from job retention services is not helpful. Ease of service accessibility at any time in the future, facilitates early intervention and smooth problem solving (for both client and employer), and is cost effective, avoiding escalating crises. It can be helpful for there to be agreed relapse prevention plans, whereby a line manager has the client's permission to contact the case manager on their behalf, should the client be exhibiting identifiable signs of stress or illness.

Principle 6: The Case Manager ensures that all agencies 'sing from the same hymn sheet'. They are assessors, negotiators, mediators and problem solvers but are also keenly aware of their limitations.

The Case Manager's task is to solicit and involve each 'player' to support the 'back-to-work' programme.

The Case Manager, through the assessments they conduct, will submit reports complete with recommendations to Occupational Health, Human Resource Departments, etc. Sometimes they need the collaboration of the General Practitioner or Psychiatrist to give 'weight' to their recommendations. On occasions, particularly when the job retention service is new, it may be

necessary to challenge the work of some health professionals, when their work related knowledge base is limited and when their intervention is hindering the back-to-work plan.

Close partnership with the client's trade union representative is essential, especially when dealing with issues such as bullying, harassment or disciplinary procedures. The Case Manager needs to advise the representative on all relevant mental health issues and the coping skills practiced by the client. When conflict arises at work then the Case Manager needs to act as mediator. If the problems are deep-seated and/or linked with organisational deficiencies, then professional mediators can be accessed on the recommendation of the Case Manager.

If the Case Manager does not enjoy the trust of all parties or feels they have an undue bias towards their client, then it would be wise to recommend external mediators. In cases such as this, the Case Manager can explain the mediation process to their client; act as an advocate for their client and advise the mediators engaged on the relevant mental health issues, explaining how this may impact on the mediation process. The Case Manager must decide when their client is emotionally resilient enough to benefit from mediation.

The Case Manager supports the client in developing greater resilience and coping skills in areas such as anxiety management, assertiveness, and general stress management. They can also offer the client solutions-based brief therapy, wellness coaching, help with identifying thinking errors etc. Non-clinical case managers, however, must recognise their limitations and know when to call in the 'experts', and therefore need to have good liaison links with community mental health teams, drugs and alcohol services, relate counsellors, for example.

Principle 7: Case Managers have worked for a significant time in mental health. Whether they work for a Healthcare Trust, a Voluntary Organisation or in the private sector, they need close ties with mental health services.

The ideal Case Manager in this area of job retention has both therapeutic and case management skills with extensive experience in mental health. Regardless of who delivers the service, they must work seamlessly with mental health services to ensure that therapy is connected with the recovery process.

Given the complexity of job retention cases, it is important for all Case Managers to receive effective training and supervision.

With General Practitioner referrals, there may be long waiting lists for counselling or Cognitive Behaviour Therapy. The Case Manager must be able to deliver a range of coping skills during the delay.

Health professionals engaged in this work should avoid 'pathologising' their clients and should be committed to recovery principles and 'solutions-based' approaches.

Job Retention provides an ideal platform for mental health professionals to engage in mental health promotion work, and to use their contact with employers to disseminate accurate knowledge and understanding about what mental health conditions actually are, (greatly needed with regard to psychotic conditions), and more importantly what we can *all* do to safeguard and improve our own mental health. Demystifying and de-stigmatising mental illness in the community as a whole, not just the workplace, should be one of the aims of all mental health services.

Principle 8: Case Managers must be familiar with the Disability Discrimination Act and Health & Safety Legislation.

Due to the adversarial nature of law courts and employment tribunals, the process of getting redress can be psychologically damaging for the client. Knowledge of the Disability Discrimination Act and the employer's 'duty of care' are useful in discussions with employers. This will facilitate the implementation of good back-to-work plans. Invariably, in cases where bullying/discrimination are incontrovertible, then the matter is settled out of court. Where recourse to law is inevitable, then it is best to delay litigation until the client feels mentally strong enough to cope.

In such cases, the free legal advice and advocacy role of a trade union representative can be invaluable. Where the client is not a member of a trade union, a number of employment law solicitors are happy to 'look at the evidence' and advise whether litigation might be successful. The Citizens' Advice Bureau sometimes have Employment Advisers who are able to represent clients at Tribunals – they often will take up cases rejected by union solicitors – with positive results!

The important thing with the Disability Discrimination Act is that the employer should be encouraged to enter into the spirit of the law, rather than seeing it as an instrument of sanction. The key clause in the legislation is 'making reasonable adjustments' for a person's return to work. On the premise that mental health has a great deal to do with good relationships, the foundation stone of a successful phased return must include attitudinal changes. A phased return, on its own, can 'gloss over' staff relationship problems.

As of October 2004, to dismiss someone on the grounds of ill-health, when that action brings about a further deterioration of the employee's mental health, can lead to a further claim for damages. Other amendments now include all employers, regardless of size and also now cover the Police Forces, hitherto exempt, under the DDA.

Principle 9: Job Retention Services present opportunities for meaningful mental health education.

As part of a client's 'back-to-work plan' there will be an opportunity to educate key staff at the employer's site on the nature of the mental health impairment and on participating positively in the return to work process. During conversations with Line Managers and Human Resource team members, the question of other employees currently 'off sick' may be raised. This is the Case Manager's opportunity to introduce the possibility of more general mental health training. The Case Manager must be prepared to recommend a variety of key resources. Health Promotion work with employers is not useful if you are only able to offer 'Saneline' or the number of the Citizens Advice Bureau. There will certainly be opportunities for supporting employers in introducing mentally healthy work place policies and 'sign up' to the 'Mindful Employer' charter and support for employers (see www.mindfulemployer.net).

Case Managers should explore the possibility of becoming Mental Health First Aiders and be able to recommend such training to employers. Mental Health Services and voluntary sector mental health organisations could begin to offer "mental health awareness training for line managers" courses.

Principle 10: Sometimes it is better to help someone find a new career path, rather than return them to the old job.

In roughly 30% of cases it will not be possible for the client to remain with the same employer. These situations are more evident where someone has found themselves in a situation where the bridges have already been burnt – usually a 'late intervention'. The severity of the illness coupled with no suitable opportunities for re-deployment can be factors. Where litigation, or out of court settlement for damages has occurred, it may be inconceivable for the client to return to their old employer. Sometimes employers have such a negative work culture that it is inadvisable for the individual to return to such an environment.

It is important for these clients to see their situation not as 'the end of the world', but rather as an opportunity for a fresh start. There is evidence that a new career path for some people brings about a new lease on life and makes them wish they had done it years ago. The important thing is to help people find another career path before they make a profession of their illness!

For people seeking a new career path, it is beneficial for the job retention service to be linked closely with those who deliver vocational rehabilitation for unemployed people. Ideally, they should work for the same organisation.

More information can be found from:

1. 'Job Retention & Mental Health – A Review of Literature – Institute of Applied Health & Social Policy, Kings College, London.
2. 'Getting back before Christmas' – Job Retention Pilot Evaluation – also Kings College.
Authors: Dr Tina Thomas, Dr Jenny Secker & Dr Bob Grove (both publications)

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