Supporting people in accessing meaningful work: Recovery approaches in community-based adult mental health services

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Executive summary

Background

Traditional clinical definitions understood 'recovery from mental health problems' as being 'free of mental health symptoms'.[35] The social model of recovery considered in this review stresses the importance of individuals having opportunities to take control of their lives and to engage in all levels of society regardless of whether mental health symptoms persist.[52] The opportunity for people who use mental health services to have access to and engage in vocational and training interventions within adult community mental health services is one aspect of supporting people's individual journeys of recovery.

Research addressing the vocational and training needs of people who use mental health services, the conceptualisation of meaningful occupation and the development of social definitions of recovery and their incorporation into research, policy and practice has increased rapidly in the past 15 years.[82] To acknowledge this movement towards adopting recovery-based approaches to ccommunity-based adult mental health services, the Social Care Institute for Excellence (SCIE) has produced a systematic map that identified research studies on recovery approaches in community-based vocational and training services. Following the completion of this systematic map, SCIE commissioned the current knowledge review on this topic.

Aims

This knowledge review aims to:

- synthesise research evidence on the process and impact of vocational and training interventions that are employing recovery approaches, in community-based adult mental health services
- survey current practice to identify vocational and training interventions being delivered in community-based adult mental health services in the UK that adopt recovery approaches.

Methodology

The research review

The review of the literature examines the relevant evidence and information on the topic and synthesises the findings to answer the research review question. This is predominantly based on the definitions, searching, screening and findings of a systematic map on the topic recently undertaken by SCIE.[46]

The research review also examines further research produced since the map searches were completed.

The research review used the broad range of methods for reviews of the EPPI-Centre[83] that conform to SCIE's recently published guidelines on conducting systematic reviews,[49] and was supported by EPPI-Reviewer software.[84] Full details of the review methodology are included in the technical appendix.

The research review had two components:

- a review of the research evidence evaluating the impact of recovery-orientated training and vocational interventions on non-vocational outcomes, for example, self-esteem or quality of life
- a review of the evidence on the process of delivering interventions that aim to impact on both vocational and non-vocational interventions.

The knowledge review (practice survey and the research review) was informed by a Project Advisory Group and an academic consultant.

Key findings

Research review: outcome studies

The research review examined the research evidence on outcomes of recovery approaches to vocational interventions on non-vocational outcomes:

- Twenty-one outcome evaluations met the inclusion criteria and were judged to be methodologically sound; they were published between 1991 and 2006 and evaluated a range of community-based training and vocational interventions measuring vocational and non-vocational outcomes.
- The majority of studies were conducted in the US (*n*=16), three in the UK and one each in Canada and Europe.
- There was little evidence to suggest that different types of training and vocational interventions lead to differences in non-vocational outcomes.
- The research evidence was not conclusive. There were inconsistent findings of the impact of training and vocational interventions on self-esteem, social capital, engagement in daily living and quality of life (see Section 3.3.7).
- Although many studies reported an effect of an intervention there were many other studies reporting no evidence of effect.
- The areas where there seemed to be consistent effects was:
  - voluntary work and supported education programmes impacting on participants' self-reports of improved self-esteem
  - supported education helping participants' ability to cope with the stress of studying
  - most studies on integrated services and voluntary work and education showing an improvement in quality of life
  - most studies on integrated services showing an improvement in engagement in daily living activities and a reduction in mental health symptoms.

The findings indicate that although training and vocational interventions are shown to have an impact on vocational engagement, vocational engagement is often weakly related to non-vocational outcomes.[11] It is likely that programme effects on

vocational and non-vocational outcomes are specific to the content and delivery of the programme. Another possibility is that people who use services need more time in employment, training or education before vocational gains can be generalised to other non-vocational domains.[85]

Research review: process studies

- Six process evaluations met the inclusion criteria and were judged to be methodologically sound; they were published between 1992 and 2006. Four were conducted in the US (n=4) and two in the UK.
- The studies identified a wide range of components of recovery approaches to vocational interventions.
- These studies were rich in suggesting components of recovery but provided minimal detail of the mechanisms by which these are achieved or what features would differentiate between successful and non-successful services.

Practice survey

The practice survey looked at the different ways in which training and vocational services can approach working with users to support them access employment, education or training to facilitate aspects of recovery. Findings indicated that practitioners used both person-centred and strengths-based approaches. Practitioners aimed at and believed in working with people to build on their strengths, competencies, accomplishments, goals and motivation and provided support with the wider aspects of people's lives including when they experienced setbacks in their mental health.

There were varying ways in which training and vocational services attempted to provide opportunities for people who use services to support each other, but it featured more as an 'add on' to services than being integral to service delivery. The user–practitioner relationship was the mechanism for providing person-centred and strengths-based approaches, but there appeared to be a tension between developing positive working relationships with people who use services, and the pressure regarding funders to have measurable outcomes such as the number of people working and 'in a job'.

In many circumstances training and vocational services need to support users to overcome barriers to employment. The most commonly cited issue was supporting people to navigate the complex and sometimes confusing route between receiving benefits and entering into employment or full-time education.

Recommendations

For policy and practice

- To deliver hybrid approaches that can support people at different points in their recovery process, as not everyone can be ready to enter competitive paid employment but may still want support to explore avenues towards obtaining meaningful occupation.

- To deliver integrated training and vocational services, such as the approach taken by the individual placement and support (IPS) model, whereby vocational specialists join existing community-based mental health teams.
- To continue building peer support into services to enable people who use services to learn and benefit from other people's experiences and insights into their own recovery processes.
- To have secure forms of funding for training and vocational services that acknowledge and validate the importance of the work they do. To provide additional funds for more services to have open-door policies, whereby people who use services know they have access to services and are not considered closed and 'recovered' simply because they re-entered the workforce.
- That services continue to have a dialogue concerning and addressing issues of the power imbalance between people who use services and practitioners and the implications this has for recovery processes.
- To provide accurate advice on and support with the welfare benefit system. This needs to be an essential part of any service that aims to support people to access work, education or other forms of meaningful occupation.

For further research

- To explore the ways in which racism, sexism, ageism and other oppressive factors can affect the recovery process and how training and vocational services and models of recovery are addressing these issues.
- To conduct user-led research which looks at whether training and vocational services allow people to determine what meaningful occupation means to them, and what they really want out of life and the extent to which services have supported and can support people to do this.
- To conduct user-led research which explores the role of training and vocational services in influencing personal definitions of what counts as a recovery-based outcome.
- To conduct user-led research which explores both practitioners' and users' perspectives and experiences of recovery-orientated approaches in the delivery of training and vocational services.
- To conduct randomised controlled trials of the effectiveness of training and vocational services on non-vocational outcomes in the UK that builds on and tests the research evidence identified in the research review on outcomes.
- To undertake process evaluation research that develops models of recovery-orientated service delivery to differentiate the use of different combinations of service, user and contextual characteristics.
- To explore the impact of vocational services, working with employers and potential employers both to support individuals and to promote further opportunities for employment of people with mental health problems.

1 Introduction

1.1 Aims and rationale

The current social care transformation policy has at its heart the personalisation of services so that people can choose the type of support that is more suited to their individual needs and preferences. The 'Putting People First' concordat outlines a shared vision and commitment to the transformation of adult social care which will mean increased choice, control and power for people who use services and carers (HM Government, 2007).59 This knowledge review focuses on an approach to delivering mental health services that is vital to achieving personalised support for those accessing opportunities for employment, education and meaningful occupation.

Personalisation in mental health services is a crucial part of this social care transformation. This knowledge review shows that practitioners and people who use services are already making headway with implementing recovery-orientated and person-centred approaches designed to promote citizenship, control and independent living. The key findings show personalised services in action: recovery includes all aspects of an individual's life and vocational processes are being seen within the wider context of people's lives; practitioners are starting to work in integrated teams on a one-to-one basis with people to build on their strengths and competencies; and research shows that individual placement and support is an effective way of supporting people with mental health problems to gain access to work opportunities.

Transformation through personalisation is happening within public services more widely and this knowledge review is also of relevance to welfare reforms, set out in the Welfare Reform Act 2007. The new Work Capability Assessment is designed to assess an individual's strengths and includes consideration of mental health issues. This knowledge review provides an evidence base on emerging models of recovery-orientated, personalised ways of working with individuals with mental health problems who are seeking ways into work.

Recovery is the process of regaining active control over one's life. This may involve discovering (or rediscovering) a positive sense of self, accepting and coping with the reality of any ongoing distress or disability, finding meaning in one's experience, resolving personal, social or relationship issues that may contribute to one's mental health difficulties, taking on satisfying and meaningful social roles and calling on formal and/or informal systems of support as needed.[52]

The process of recovery for people with mental health problems is a lived experience.[76] Previous clinical definitions understood recovery as being free of mental health symptoms.[35] The social model of recovery considered in this review stresses the importance of individuals having opportunities to take control of their lives and to engage in all levels of society regardless of whether mental health symptoms persist.[52] The opportunity for people who use mental health services

to have access to and engage in vocational and training interventions within adult community mental health services is one part of the social model of recovery.

Research addressing the vocational and training needs of people who use mental health services, the conceptualisation of meaningful occupation and the development of social definitions of recovery and their incorporation into research, policy and practice has increased rapidly in the past 15 years.[82] To acknowledge this movement towards adopting recovery-orientated approaches to community-based adult mental health services, the Social Care Institute for Excellence (SCIE) has produced a systematic map which identified research studies on recovery approaches in community-based vocational and training services.[46] On completion of this systematic map, SCIE commissioned the current knowledge review on this topic.

The knowledge review comprises both a practice survey and a research review:

- **The research review:** synthesises the research evidence on the impact and process of vocational and training interventions using recovery approaches in community-based adult mental health services.
- **The practice survey:** presents finding from an online postal survey and in-depth telephone interviews of vocational and training practice using recovery approaches in England, Wales and Northern Ireland.

Figure 1.1: Knowledge review structure

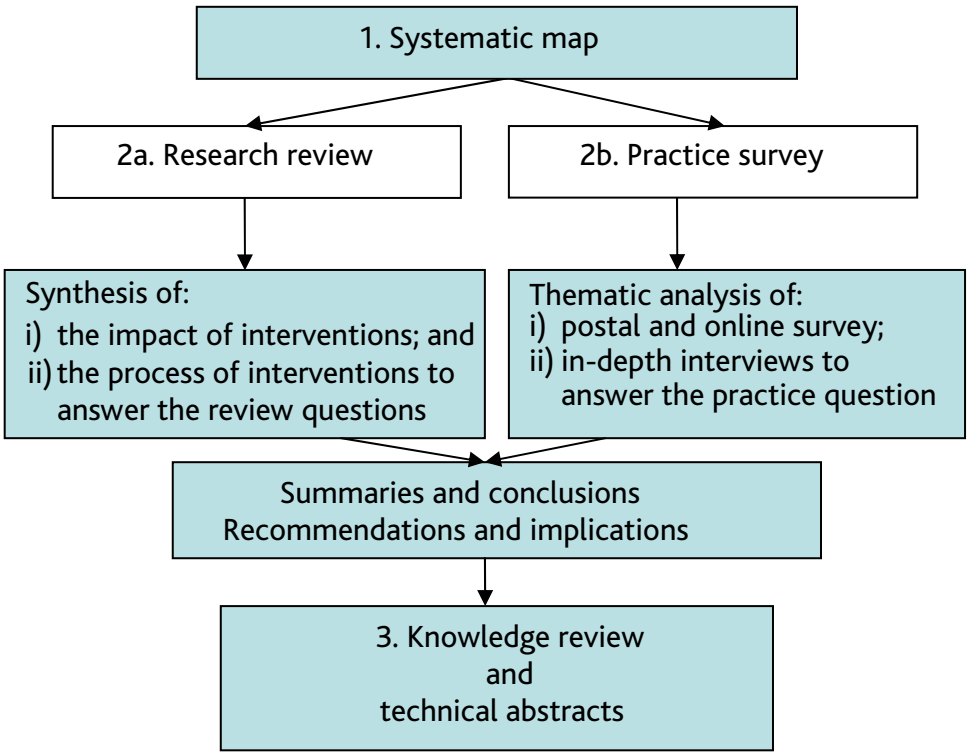


Figure 1.1 illustrates how the different components of the project work together, starting with the systematic map, the research review and practice survey, finishing with the final product, the knowledge review.

1.2 Concepts and definitions

Recovery is a contested term and there is no agreed UK definition of what recovery means or definition of what can be regarded as recovery-orientated approaches in community-based mental health services. In order to address this gap, the Care Services Improvement Partnership (CSIP), Royal College of Psychiatry (RCP) and SCIE commissioned a joint position paper on recovery.[52] The paper describes the history and concept of the recovery model in mental health; establishes values and principles concerning mental health recovery; describes how the recovery model can be used in practice; promotes the relevance of user-defined outcomes; and considers the impact of recovery model approaches on people who use diverse mental health services. The aim of the paper is to generate awareness of recovery and to generate further discussion of recovery-orientated approaches and how they are applied in the UK.[52]

Recovery and recovery-orientated approaches in community-based mental health services are conceptually distinct from rehabilitation and the provision of traditional rehabilitation services. Recovery emphasises working in partnership with people who use mental health services, their families and other agencies, rather than taking a *doing to* approach, commonly a feature of many rehabilitation-based services.[82] The recovery approach specifically emphasises the individual being empowered to make decisions and to take control over their own life. Rehabilitation services have a developmental history that bridges policy changes such as deinstitutionalisation, community care and social inclusion, working to reduce the impact of stigma and to promote recovery. Moving away from segregated day services, the adoption of recovery-orientated approaches, and promoting the ethos of recovery throughout rehabilitation service provision, is a new direction in mental health service provision.[77]

1.2.1 The recovery model

The definition of recovery used in the systematic map was based on work developed by the US Department of Health and Human Services Administration and the Interagency Committee on Disability Research. This has been reported in the *National consensus statement on mental health recovery*[86] and was agreed by over 110 experts including people who use services, carers, service providers, commissioners, advocates, academics and policy makers.

The following nine components of recovery were identified in the consensus statement:

- self-direction
- individualised and person-centred
- empowerment
- holistic
- non-linear
- strengths-based
- peer support
- respect

- responsibility
- hope.

The knowledge review has used the map's definition of recovery and also includes:

- social inclusion

Social inclusion is relevant to this knowledge review because it relates to individuals undertaking valued social roles and participating in mainstream social activities and networks.[82]

1.2.2 Community-based adult mental health services

Community-based mental health services are defined broadly in the knowledge review as services that are delivered as part of community services and not in psychiatric hospitals.

Community-based adult mental health services also include services that aim to:

- enable and empower people who use mental health services so that they can take an active part in the community
- enhance the participation and inclusion of mental health services users in the community.

1.2.3 Vocational and training services

For the purpose of the knowledge review vocational and training services are defined as services which:

- provide vocational training, advice and/ or skills, OR
- support the user in a paid or unpaid employment or in education AND
- aim to assist people who use mental health services access, maintain or regain employment (paid or unpaid), education and other meaningful occupations.

The systematic map and the knowledge review are concerned with community-based vocational and training interventions and so cannot include all the interventions that a broad term such as 'meaningful occupation' could imply. The definitional boundaries are necessarily arbitrary and not everyone may agree with our definition of 'meaningful occupation' and some important interventions may fall outside the scope of the review.

The concept of 'aiming to assist' people who use mental health services is understood as a relationship between the user and the service provider. This is to identify the difference between service providers that adopt *doing to* attitudes and behaviours compared to service providers that adopt *doing with* attitudes and behaviours when delivering community-based training and vocational interventions.

This knowledge review has applied these definitions of recovery and community-based adult mental health vocational and training services to inform how we:

(a) identified which studies to include in the scoping review of the research literature;
(b) identified which community-based vocational and training services to survey
(c) identified which studies were included in the research review.

1.3 Policy and practice background

The recovery model is being used as a core principle in mental health service reform in the US, Australia and New Zealand. The New Zealand Mental Health Commission have developed specific 'recovery competencies' for mental health workers in partnership with people who use mental health services.[74] Similar recovery-orientated mental health policy and practice reforms are being explored as a possible approach to the development of more holistic, person-centred mental health services across the UK.

In 2001 the Department of Health published *The journey to recovery*,[53] which stated that the mental health system 'should support people in settings of their own choosing and enable access to community resources including housing and work or whatever they felt was crucial to their recovery'.[66] CSIP has subsequently released guidance on commissioning community-based services in England which take into account a recovery approach.[88]

The National Social Inclusion Programme for England has been working across government departments to develop policies and initiatives that support people with mental health problems to enter and retain work.[70]

The Sainsbury Centre for Mental Health now has a focus on developing projects and promoting new ways of helping people with mental health problems get and keep work. The organisation is hosting the National Employment and Health Innovations Network and the Mental Health and Employment Research Network (co-hosted by CSIP and RCP). The organisation has also recently produced a policy document on making recovery a reality, which recognises some of the issues around recovery and employment.[79]

Following on from the NHS Wales White Paper *Quality care and clinical excellence*,[89] *The revised National Service Framework for mental health in Wales*[90] has made social inclusion and the promotion of opportunities for a normal pattern of daily life part of its eight key standards.[87]

Northern Ireland's *Promoting mental health: Strategy and action plan 2003-2008* aims to improve the life circumstances and life skills of people with mental health problems. The action plan includes workplace stress, stigma, social inclusion, learning, training and employment.[54]

The Scottish Recovery Network has been active in promoting recovery-orientated approaches. Part of their aims is to engage communities across Scotland in a debate on how best to promote and support recovery across mental health services (www.scottishrecovery.net).

The 'in Control' project, which promotes personalisation through self-directed support by people who use adult social care services, has published work on the implications of this model for people with mental health problems. A report entitled *A voice and a choice*[37] explores how the recovery approach can fit with the choice, control and independent living offered by self-directed support: 'Self Directed Support must surely allow the possibility that more people will find their own ways to stay well enough not to need a crisis response, and since they are choosing how and who provides support, they are more likely to be successful in their recovery journey'.[37]

1.4 Research background

The relationship between the social model of recovery and interventions which seek to work with and assist people who use mental health services in employment, education or other meaningful occupation and activities continues to be discussed, explored and evaluated in the research literature. The brief overview provided here reflects the research that has been identified in the map supplemented with additional literature on a supported employment evaluation recently undertaken in the UK. The research review provides more detail about what we know from the studies and the practice survey informs us about current innovative practice taking place in the UK that has not yet be formally described and/or evaluated.

Research on vocational and training interventions has included: evaluations of the effectiveness and implementation of traditional vocational rehabilitation approaches;[51] evaluations of the different types of supported employment currently being offered;[43] evaluations of the effectiveness of supported education[47, 62] and, more recently, the views of people who use services and their experiences of working and how they define meaningful occupation.[61]

The research literature on the process and impact of vocational and training interventions in community-based adult mental health services has centred round three main areas: traditional vocational rehabilitation interventions; supported employment; and supported education.

Traditional vocational rehabilitation interventions

Evaluations of traditional vocational rehabilitation interventions conclude that they are not necessarily a useful way for individuals to sustain long-term employment.[44] The two main reasons cited for this are: the lack of ongoing support once assessment, placement and pre-vocational training has been completed, and the reduction in individual earnings once an individual is in a job.[51] The lack of information about the financial implications paid work has on benefits and a disinterest in the long-term support required for people who use mental health services to sustain working patterns has led to the popularity of supported employment models.[65]

Clubhouse model

Founded in 1948, by 1999 there were 173 clubhouses located all over the US. They aim to create a therapeutic community comprising of staff and members (patients

or clients with mental illness) who work in the clubhouse or who can go there to spend time. The aim is to provide members with voluntary vocational jobs within the clubhouse and paid employment outside.[67]

Members are provided with individual tutoring and vocation and social skills training. This is done by running a business-like environment where members can be employed within the clubhouse model in administrative services like publishing newsletters, running the programme, answering telephones and emails; in an employment unit to perform clerical duties, typing, computer operations; or in food services to cook, shop, serve meals etc.[1, 29]

Supported employment

Supported employment can refer both to employment status and employment service.[43] Supported employment has been heavily influenced by the work of Becker et al[41] in the development of the individual placement and support model (IPS). IPS is defined by its focus on developing services which concentrate on competitive employment; eligibility based on user willingness to work; rapid job searches, with supported employment closely integrated with any mental health teams required by the user; and person-centred and long-term support practices.[43]

The majority of randomised and controlled trials evaluating the impact on supported employment on vocational and vocational outcomes have been based on interventions delivered in the US. The lack of an evidence base in Europe has led to the conduction of an international six-centre randomised controlled trial that included sites in London, Zurich and Sofia. The study compared IPS to vocational rehabilitation and found IPS was more effective than vocational services for every vocational outcome, with 55 per cent of patients assigned to IPS working for at least one day compared with 28 per cent of patients assigned to vocational services.[38] Further analysis of the findings has found that participants who have worked previously with stronger support systems are more likely to obtain employment and stayed employed for longer periods of time.[39] The impact of IPS compared to traditional vocational rehabilitation on non-vocational outcomes has been measured but is yet to be reported. In addition, the European Social Fund has commissioned a two-year UK project on 'Social Inclusion through Employment Support for Adults with Mental Illness' (www.sesami.org.uk), the results of which are yet to be widely available. Their remit has been to contribute to knowledge about how people with severe mental health problems can be helped to find and keep employment. Their work includes looking at whether IPS is being implemented across six partner agencies, measuring their success and exploring users' and service providers' views about what works in supporting users towards employment, meaningful occupation and recovery.

Supported education

Over the last 15 years supported education interventions have also become more prominent in community-based mental health services.[71] The aim of supported education programmes is not only to support mental health users' access and continuing participation in post-secondary education, but to provide access to

leisure, recreational and cultural resources and work with adult mental health users to identify, explore and take part in vocational and training services.[48] Although supported education models take on various forms, their overall aim is to provide ongoing support to assist mental health users to retain and access skill, career and education opportunities.[81]

This knowledge review includes a research literature on:

- traditional vocational rehabilitation interventions
- supported employment
- supported education
- other interventions that aim to support people in accessing, maintaining or regaining employment, education and other forms of meaningful occupation.

2 Knowledge review approach

The knowledge review was conducted in accordance with SCIE guidelines and to EPPI-Centre (Evidence for Policy and Practice Information Coordinating Centre) and SCIE procedures for conducting a systematic review. The EPPI-Centre procedures for identifying and synthesising studies have been followed for the research review. SCIE's experience on conducting the practice survey and combining practice and research has been utilised. EPPI-Reviewer software[84] was used to complete the screening and coding of all citations and the data extraction of studies in the research review.

2.1 Scoping and map of the literature

The scoping and systematic map on 'the recovery approach in community-based vocational and training adult mental health services' was undertaken by the SCIE work programme support team. The main of objectives of the map were to provide an overview of and access to research on:

- implementing recovery approaches in vocational and training-focused community-based mental health services
- person-centred outcomes of recovery-orientated vocational interventions including user views
- effectiveness of interventions undertaken in vocational and training-focused community-based mental health services.

The map acts as a driver for this knowledge review and provides a starting point from which to identify studies to include in the practice survey and research review.[46]

2.2 Knowledge review questions

The knowledge review:

- surveys current practice to identify vocational and training interventions being delivered in community-based adult mental health services in the UK which adopt recovery approaches and
- synthesises research evidence on the process and impact of vocational and training interventions that are employing recovery approaches, in community-based adult mental health services.

The practice survey asks:

How do community-based adult mental health vocational and training services using recovery-orientated approaches operate in the UK?

The research review asks:

- What is the impact of training and vocational interventions employing recovery-orientated approaches in community-based adult mental health services on non-vocational outcomes?
- What is the process of implementing training and vocational interventions employing recovery-orientated approaches in community-based adult mental health services?

2.3 Ethics

The research project has been subject to formal ethical review by the ethical committee of the Faculty of Children and Health at the Institute of Education. The practice survey required practitioners to give information about the services they provide before taking part. The practice survey monitored services and therefore did not need to obtain additional ethical clearance from the NHS National Research Ethics Services (NRES) to undertake the in-depth interviews (www.nres.npsa.nhs.uk/news-and-publications/publications/nres-research-leaflets/).

2.4 User involvement

The knowledge review was informed by a Project Advisory Group and a project consultant. Please refer to the technical appendix for details of the user involvement approach and methods.

2.5 Limitations of the knowledge review

As outlined in Section 1.2.1 the knowledge review builds on the search strategies and keywording of the systematic map. Any limitations of the map will be reflected in the studies included in the research review and the overall conceptual framing of the knowledge review.

Within time and resource constraints it was not possible for the systematic map to look at all aspects of the recovery model. The decision was made to look at the recovery approach in training and vocational services. However, this is just one aspect of the recovery model that can be researched.

The systematic map identified a large number of studies looking at the impact of training and vocational interventions on vocational and non-vocational outcomes. It could be argued that looking at the impact of training and vocational outcomes on non-vocational outcomes is not congruent with the recovery paradigm as any outcome can be a recovery outcome. However, it could also be argued that this has been a ground-clearing exercise which demonstrates that the evidence base in this field of enquiry lacks user-led input that would benefit our understanding of the recovery process and it how it relates to our understanding of meaningful occupation, activity and engagement.

None of the studies included in the research review explicitly addressed the issue of diversity and the specific issues that face people from marginalised groups. The

impact of gender, race or sexuality was rarely addressed. Thus it is not possible from this research review to draw conclusions about the relationship between sexism, racism or homophobia on the impact it may have on the effectiveness of training and vocational interventions.

Part of the original remit for the knowledge review was to survey current UK practice to bridge any gaps there might be in the evidence base. The practice survey provides specific examples of recovery-orientated practice currently taking place in training and vocational services in the UK. However, because of resource constraints we have not been able to verify the data with testimonies from people who use services or explore in any detail their personal experiences of recovery and vocational processes. As detailed in Section 5.4 further user-led research is required in all aspects of research within the recovery paradigm.

The sample for the practice survey was limited in a number of ways. Firstly, the practitioners who responded may not be representative of practitioners working in training and vocational services across the UK. This limitation stems from not being able to construct a reliable sampling frame for practitioners working in this field. Secondly, the low response rate is typical of online and postal survey designs. Thirdly, the use of open-ended questions in the survey meant that the survey was more time consuming than if we had only used closed questions. In addition, although we did not use the term 'recovery', it may have been implicit in the title of the survey and attracted only those practitioners who already felt confident that they were using approaches compatible with a social model of recovery.

3 Research review

3.1 Introduction

This research review is about the use of recovery approaches in community-based adult mental health services that aim to support people in accessing work, education and other forms of meaningful occupation. It has two components:

- a synthesis of findings from the literature on impact recovery-orientated training and vocational interventions on non-vocational outcomes
- a synthesis of findings from the literature on the process of delivering recovery-orientated training and vocational interventions.

The methods are predominantly based on the definitions, searching, screening and findings of a systematic map as outlined in Section 2, which also provides information on the update of the systematic map and how we moved from the systematic map to review a subset of coherent studies to answer the research review questions.

3.2 Methodology

The research review used the broad range of methods for reviews of the EPPI-Centre[83] which conform to SCIE's recently published guidelines on conducting systematic reviews,[49] and was supported by EPPI-Reviewer software.[84]

The review of the literature examines the relevant evidence and information on the topic and synthesises the findings to answer the research review question. This is predominantly based on the definitions, searching, screening and findings of the systematic map on the topic recently undertaken by SCIE.[46]

The technical appendix that accompanies this knowledge review provides details of the research review methodology and details of the studies included in the research review. The technical appendix contains:

- details of the updated search strategy
- details of the inclusion and exclusion criteria for the systematic map and research review
- application of the inclusion and exclusion criteria (screening)
- how studies were assessed for their quality and relevance
- how studies were synthesised
- quality assurance processes
- methods for and coding tool used to extract data from the studies included in the research review
- structured abstracts for the systematic reviews excluded from the research review
- structured abstracts for each study included in the research review.

3.2.1 Update of the systematic map

The research review examines further research produced since the map searches were completed. Table 3.1 gives the origin of all reports found and added to the research review.

Table 3.1: Origin of included papers

Database	No of studies found
ASSIA	5
CINAHL	2
Medline	4
Psycho	0
Embase	0
Zetoc	0
IBBS	0
Sociological Abstracts	0
Total	11

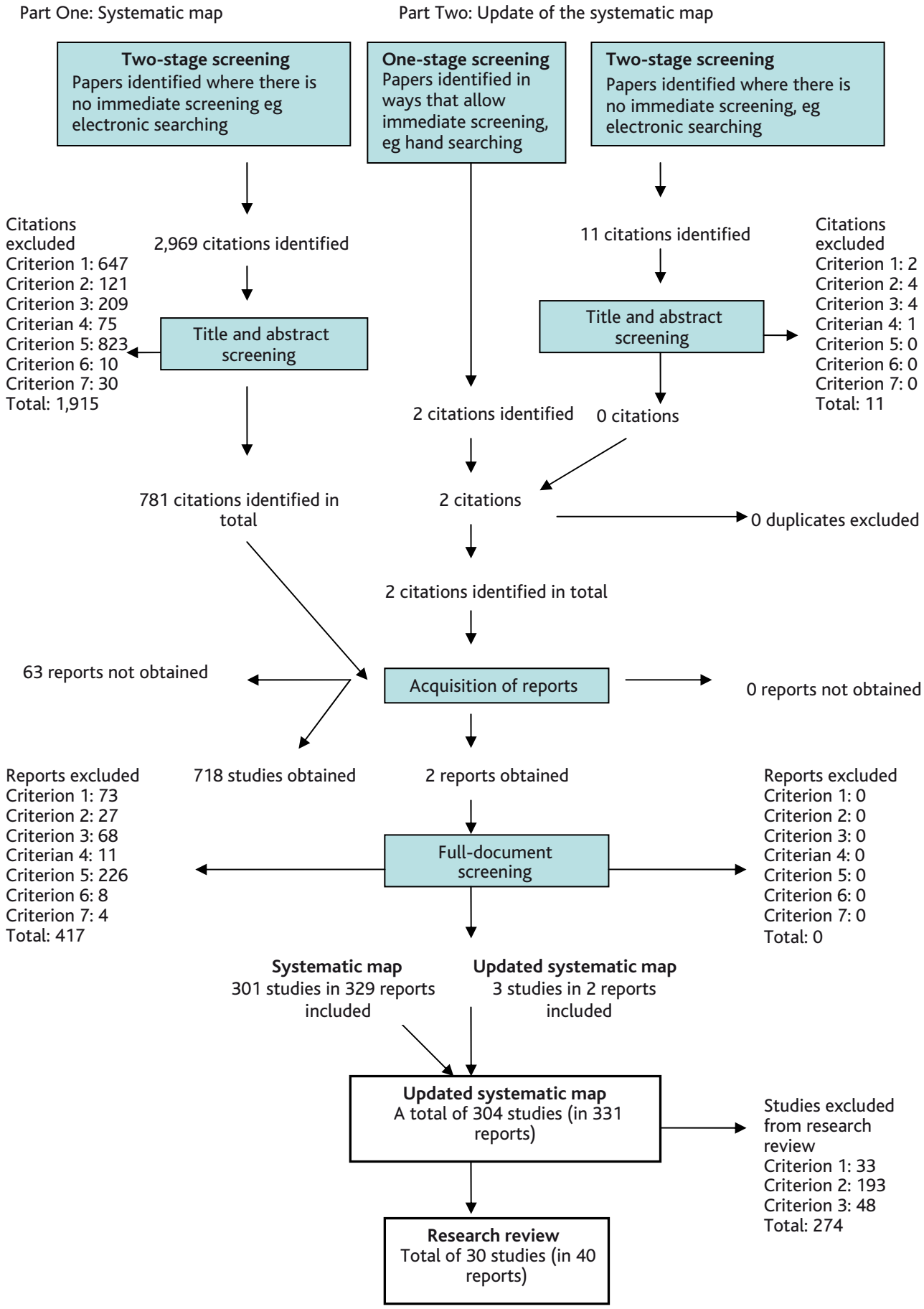
The 11 reports identified from updating the original electronic database searches were screened by title and abstract. All of the studies were excluded using the map criteria. A total of two studies were identified and included from hand searching websites and online journal articles (see the technical appendix for further information).

The additional studies that have been included in the research review have been coded using the standard SCIE keywording tool for social studies,[36] and an additional tool for review-specific keywords. The remaining studies in the research review have already been keyworded.

A total of 304 studies in 331 reports potentially relevant to our review were identified from the systematic map and update of the systematic map. These 304 papers went through to the full-text screening stage. Full texts papers included in the systematic map were obtained from the SCIE library. Two of the three studies identified from the update of the systematic map were sourced online; the remaining study was sourced from a key contact. Exclusion criteria were then re-applied to full documents. A total of 274 studies were excluded, leaving a total of 30 studies in 40 reports included in the research review.

Figure 3.1 illustrates the process of filtering of studies from both the systematic map and from the update of the search to the research review.

Figure 3.1: Filtering of studies from the systematic map and update of the systematic map



3.3 Research synthesis: outcome evaluations

This section of the knowledge review includes the findings of the outcome evaluations identified from the systematic map and update of systematic map. Outcome evaluations aim to evaluate the impacts or changes to people who use services as a result of participating in an intervention. Outcome evaluations can measure these changes in the short, intermediate or long term.

A synthesis of the evidence available to answer the research review question is presented.

The research review question was:

What is the impact of training and vocational interventions employing recovery approaches in community-based adult mental health services on non-vocational outcomes?

To answer this question we have conducted a synthesis of findings from a diverse range of study designs. The synthesis is the combination of findings of all the different included studies in a review. The findings are based on studies we appraised for quality and relevance and which measure non-vocational outcomes. Before looking in detail at the findings in the studies we grouped them according to the following three intervention types: integrated services, vocational training and voluntary work and education.

3.3.1 Intervention types

Integrated services

Integrated services refer to interventions that provide vocational services within existing community-based mental health settings. The focus is to provide a specialist employment service that focuses exclusively on participants gaining competitive employment promptly while maintaining a close and collaborative working relationship with existing mental health teams. These included generic supported employment models and studies on the IPS model.

Vocational training

Vocational training refers to interventions that provide services within a variety of community-based settings and can often include a longer preparatory training period before entering into different forms of employment, such as transitional employment, depending on the needs and requirements of people who use services.

Voluntary work and education

Interventions that aimed to increase participants' education opportunities, to provide support in education settings and increase future employment prospects were grouped under this intervention heading.

Based on the conceptual model (outlined in Section 1.2.1), we considered the extent to which each intervention type met the following recovery dimensions by asking the questions (also used in the practice survey):

- Is the service tailored to support the aims and aspirations of each individual user? (person-centred)
- Do practitioners work with people who use mental health services to recognise and build on any strengths? (strengths-based)
- Does the support provided by the service link with other aspects of a person's life? (holistic services)
- Does the service support people when they experience setbacks in their mental health? (flexible and non-linear services)
- Does the service enable people who use mental health services to provide support to one another? (peer support)
- Do practitioners work with people who use mental health services to develop and maintain constructive working relationships based on mutual respect? (service user–practitioner relationship – respect)
- Does the service encourage people who use services to take responsibility for their actions and progress? (user–practitioner relationship – responsibility)
- Does the service give people the message that they can achieve their goals? (user–practitioner relationship – hope)
- Does the service link in with other mainstream services and activities in the community? (social inclusion)

Where data was available we considered the impact of vocational and training interventions on the following four groups of non-vocational outcomes: self-esteem; social capital; engagement in daily living activities; and quality of life.

3.3.2 Outcomes

Self-esteem

Self-esteem refers to self-reported measures people assign to their worth, value or importance. It is often used as an outcome measure in studies looking at the impact of training and vocational interventions based on the hypothesis that participating in meaningful occupations leads to improvement in self-esteem. This hypothesis is based on the assumption that self-esteem changes as a result of life events and treatment interventions. Employment could also result in an increase in self-worth and the role of vocational interventions on self-esteem should be explored.[85]

Social capital

Social capital refers to measurement of participants' perceived improvements in their social support networks, social relationships, social contacts and community participation. Social capital can have many components such as behavioural (for example, participation), cognitive (for example, trust), bonding (for example, feeling of community and belongingness) etc.[68] A systematic review by De Silva et al[68] shows that cognitive social capital (feelings of trust and reciprocity) were shown to be inversely associated with common mental disorders.

Table 3.2: Weight of evidence (WoE) ratings for outcome studies

Study	WoE A	WoE B	WoE C	Overall WoE D
Accordino and Herbert (2000)[1]	Medium	Medium	High	Medium
Bailey et al (1998)[2]	Medium	Medium	High	Medium
Becker et al (2001)[3]	Medium	Medium	Medium	Medium
Browne (1999)[6]	Medium	Medium	Medium	Medium
Chandler et al (1996)[7]	Medium	High	Medium	Medium
Danley et al (1994)[8]	Medium	Medium	Medium	Medium
Drake et al (1999)[10]	High	High	High	High
Drake et al (1996)[11]	High	Medium	Medium	Medium
Ellison et al (1999)[12]	Medium	Medium	Medium	Medium
Hagner et al (1999)[15]	Medium	Medium	Medium	Medium
Isenwater et al (2002)[18]	Medium	High	Medium	Medium
Latimer (2006)[19]	High	High	High	High
McGilloway and Donnelly (2002)[20]	Medium	Medium	High	Medium
McGrew et al (2005)[21]	High	High	High	High
Mowbray et al (1999)[22]	High	High	High	High
Mowbray et al (2000)[23]	High	High	High	High
Mueser et al (2004)[24]	High	High	Medium	High
Ratzlaff et al (2006)[25]	High	High	High	High
Rogers et al (2006)[26]	High	High	High	High
SESAMI (2006) [78]	High	High	High	High
Warner et al (1999) [29]	Medium	High	Medium	Medium

Engagement in daily living activities

Engagement in daily living refers to improvements in a person's ability to carry out activities of daily living. It includes improved levels of social, psychological, physical or occupational engagement in everyday life. It can be indicated by improved scores on the Global Assessment of Functioning scale[34] or by reduction of symptom relief.

Quality of life

Quality of life measures included overall satisfaction with life, satisfaction with finances and measures of hope, confidence and motivation. Research by Evans et al[57] has shown that people with severe mental illness (SMI) score low on subjective quality of life ratings as compared to the healthy population. Quality of life in

individuals with SMI is associated with aspiration. Hope may be an important determinant of the quality of life, as quality of life is more likely to be associated with perceived life opportunity in people with serious mental health problems.

3.3.3 Overview of outcome evaluations

Twenty-one outcome evaluations met our inclusion criteria and were judged to be methodologically sound; they were published between 1991 and 2006 and evaluated a range of community-based training and vocational interventions measuring vocational and non-vocational outcomes. The majority were conducted in the US (*n*=16), three in the UK and one each in Canada and Europe. Of the 21 outcome evaluations seven were either a controlled trial or a randomised controlled trial. The remaining six outcome studies were single group evaluations. Vocational outcomes were the primary outcome measured (*n*=21) and many studies also measured the impact of interventions on the individual (for example, self-esteem, quality of life; *n*=16) or social-based outcomes such as social inclusion and social networks. All of the outcome evaluations collected non-vocational outcome data from users' self-ratings, views and experiences (*n*=21).

3.3.4 Quality and relevance of outcome studies

Two reviewers independently extracted data from individual studies by answering questions about: the aims and rationale of the study, execution of method, sampling strategy, internal and external validity, results and conclusions and generalisability of the findings. The coding tool used to extract data from each study can be found in the technical appendix. The weight of evidence (WoE) contributed by each study was assessed through careful assessments and re-reading of the study and all the answers provided. Each data extraction was carried out blind and answers to all the data extraction questions and WoE were compared. Discussion about any discrepancies was made at this time and final judgements were agreed.

- WoE A derived from the detail of the data extraction. It was a measure of the overall soundness, quality and trustworthiness of the study in terms of internal methodological clarity, coherence and internal and external validity. None of the studies were considered to be of low-quality evidence. Ten studies were considered to be of high WoE and the other 10 were considered to be medium WoE on A.
- WoE B was determined by the methodology used to evaluate the intervention. All of the studies used explicit methods for evaluating the intervention and measured non-vocational outcomes using either standardised scales or interview schedules. All of the studies were rated as either medium (*n*=9) or high (*n*=12).
- To determine WoE C we looked at the representativeness of the2 study population. Studies which included participants with different mental health diagnoses, or a broad age range of participants with a diverse vocational background were rated as high (*n*=11); studies which narrowed down on either of those criteria were weighted as medium (*n*=10).
- The overall WoE D was taken as an average of A, B or C. Nine studies were rated as high overall and 12 studies were rated as medium overall for this review. None of the studies were given a low of evidence on A, B or C.

Table 3.3: Recovery-orientated approaches

Study	Recovery dimensions						
	Person-centred	Strengths-based	Holistic service	Flexible service (non-liner)	Peer support	User–practitioner relationship	Social inclusion
Integrated service							
Bailey et al (1998)[2]	X	X	X	X		X	
Becker et al (2001)[3]	X	X	X	X		X	
Chandler et al (1996)[7]	X	X	X	X		X	
Drake et al (1999)[10]	X	X	X	X		X	
Drake et al (1996)[11]	X	X	X	X		X	
Latimer (2006)[19]	X	X	X	X		X	
McGilloway and Donnelly (2002)[20]	X	X	X	X		X	
McGrew et al (2005)[21]	X	X		X		X	
Mowbray et al (2000)[23]	X	X	X	X		X	
Mueser et al (2004)[24]	X	X	X	X		X	
SESAMI (2006)[78]	X	X	X	X		X	
Vocational training							
Accordino and Herbert (2000)[1]	X	X				X	
Browne (1999)[6]	X	X				X	
Danley et al (1994)[8]	X	X				X	
Rogers et al (2006)[26]	X	X				X	
Warner et al (1999)[29]	X	X				X	
Voluntary work and education							
Ellison et al (1999)[12]	X				X	X	
Hagner et al (1999)[15]	X	X	X	X	X	X	

Study	Recovery dimensions						
	Person-centred	Strengths-based	Holistic service	Flexible service (non-liner)	Peer support	User–practitioner relationship	Social inclusion
Isenwater et al (2002) [18]	X	X	X	X			
Mowbray et al (1999)[22]	X	X	X	X	X	X	
Ratzlaff et al (2006)[25]			X			X	

3.3.5 Recovery dimensions of outcome evaluations

Studies included in the research review of outcome evaluations were coded according to the recovery dimensions outlined in Section 1.2.1. Each study was coded and then grouped according to type of intervention.

Integrated services

Eleven of the 21 evaluation studies can be categorised as integrated services. The overall aim of the interventions in this category was to integrate mental health and vocational services by having employment specialists join multi-disciplinary teams to assist people who use services in finding competitive employment based on their individual choices and strengths. After users have secured competitive employment the aim is to provide individualised follow-on support and to identify and tackle any barriers to sustaining employment. None of the interventions categorised as integrated incorporated peer support into their programmes. Although the aim of many of these interventions is to increase social inclusion, how employment services linked in with the wider community was not described as an explicit part of the service.

Vocational training

Five of the 21 evaluation studies can be categorised as vocational training. All of the interventions in this section adopted the same type of recovery-orientated approaches. Their emphasis lay in being person-centred, finding ways into employment by looking at the strengths and capabilities of each individual and emphasised the importance of strong user–practitioner relationships. They did not explicitly describe the ways in which they supported people once in employment or methods of peer support or how they linked in with services within the wider community.

Voluntary work and education

Five of the 21 evaluation studies can be categorised as interventions that focus solely on participation in voluntary work or education. There was more variation between the different recovery-orientated approaches adopted by each intervention although they all had characteristics in common. Four of the five studies provided an outline of the person-centred approaches used and three of those studies inferred different ways in which they focused on the strengths of an individual. Three studies evaluating supported education used peer support as part of their recovery-orientated approaches. Again, positive user–practitioner relationships also featured heavily, as did providing support for people who use services when they experienced setbacks in their mental health.

3.3.6 The impact of training and vocational interventions on non-vocational outcomes

Self-esteem

Effects of integrated services on self-esteem

All of the 11 studies evaluating integrated services measured self-esteem. Six were rated as having a high WoE and five were rated as medium WoE for this review. Of the six pre-post test studies rated as having a high WoE five reported statistically significant ($p<0.05$) improvements in overall self-esteem.[10, 19, 21, 23, 78] Only one study rated as high[24] showed no statistical improvement in self-esteem. Latimer[19] cautions that the significantly statistical rise reported in self-esteem for the intervention group ($p<0.01$) in their study could have been a result of the noticeably lower self-esteem measured at baseline.

Of the five pre-post test studies rated as medium WoE for this review, three showed no statistically significant improvement in self-esteem.[2, 3, 7] One study[20] found a statistically significant increase in overall self-esteem at 12 months ($p<0.05$). However, Drake et al[11] report improvements in self-esteem during the middle part of the study ($p<0.05$ at 9-12 months) but this improvement was not sustained when measured again at the 18-month follow-up.

Effect of vocational training on self-esteem

Only one study out of the five evaluating the effects of vocational training on non-vocational outcomes measured self-esteem.

Rogers et al,[26] a high weighted study, randomised 70 people who use mental health services to an experimental intervention which was based on the 'choose-get-keep' process of vocational rehabilitation and 65 users to a control intervention which was an enhanced state vocational rehabilitation service. They measured participants' self-ratings of self-esteem using Rosenberg's self-esteem scale at 24 months, but did not find a statistically significant improvement or any significant differences between the control and comparison group or between unemployed or employed groups over time.

Effects of voluntary work and education on self-esteem
Four out of the five studies looked at the impact of work experience and education on non-vocational outcomes measured and found an improvement in self-esteem. Two of the studies were rated as high WoE for this review[22, 25] and two of the studies were weighted as medium WoE for this review.[12, 18]

Of the two high weight studies for this review, Mowbray et al[22] randomly allocated students to three groups (classroom condition, group support condition and individual condition). They found that all groups had statistically significant increases in self-esteem at the 12-month follow-up over baseline levels ($p<0.05$). Ratzlaff et al[25] carried out a one group pre-post test design and found that students who participated in a consumer provider programme, that combined classroom learning and internship activities, reported an increase in their perception of self-esteem.

Two pre-post studies weighted as medium for this review looked at the impact of supported education on self-esteem. Ellison et al[12] found a statistically significant increase in self-esteem when measured at six months into the study ($p<0.05$). In the Isenwater et al (2002)[18] questionnaire data indicates that students' perception of their self-esteem appeared to have increased over time.

Social capital

Effects of integrated services on social capital
Five out of 11 studies looked at the impact of integrated services on social capital. Of the five pre-post test studies, three were rated as having a high WoE and two were rated as having a medium WoE for this review.

Of the four studies rated as high WoE, Mowbray et al[23] found that participating in an intervention which included both peer support specialists and vocational specialists led to students' increase in community participation ($p<0.05$). However, Latimer[19] did not find any statistically significant improvement in participants' social support networks over time. Whereas, Mueser et al[24] found that there was a trend for people who use services in the comparison group, who received the psychosocial rehabilitation programme, to report increased satisfaction with their social relationships than those who received the integrated (IPS) services or standard mental health services.

Two pre-post test studies that were rated as medium WoE for this review looked at whether the number of social contacts increased over time[3] and participants' perception of improved social support networks[3] found that for one intervention condition, a secondary impact of gaining competitive employment was an increase in the number of contacts made with friends and family (per week). However, the second intervention condition reported a decrease in contacts with friends and family (per week). Chandler et al[7] found that participants from two intervention conditions who received integrated services reported an increase in the number of friends and family on whom they felt they could depend when interviewed at the end of a two-year study.

Effects of vocational training on social capital

Three out of the five studies evaluating vocational training measured improvements in social capital. One study is rated as high WoE for this review and three are rated as medium WoE.

Rogers et al,[26] a high weighted study for this review, used a 30-item scale designed to assess perceptions of social support. They measured at baseline and at 24 months but did not find any statistically significant changes in participants' satisfaction with their social support networks.

Two of the three pre-post test studies rated as medium WoE for this review found an improvement in their social relations[6] and the number of close friends they had.[29] Danley et al[8], however, did not find any change in satisfaction with social supports or frequency of social contact.

Effects of voluntary work and education on social capital

Three out of five studies reported the impact of supported education on social capital. One study was rated as high[22] and two studies were rated as medium for this revie.[15, 18]

The study by Mowbray et al[22] did not find that the number of people in participants' wider social support networks increased as a result of the taking part in a supported education intervention. However, Hagner et al[15] found that people did made social contacts and established friendship with others participating in the supported education programme. Whereas, participants in the study by Isenwater et al[18] stated that they felt taking part in the supported education programme helped them develop social skills which could potentially lead to stronger social support networks.

Engagement in daily living activities

Effects of integrated services on engagement in daily living activities

Nine of the 11 studies looking at integrated services measured the improvements in engagement in daily living activities and reduction in symptoms. Five of the nine studies were rated as high WoE and four studies were rated as medium WoE for this review. Four out of the five studies rated as high WoE reported statistically significant improvements in this domain.[10, 21, 23, 24]

McGrew et al[21] found that statistical measures of engagement were equivalent between the condition and control groups at six months but were significantly higher for the condition group at both three-month ($p<0.05$) and 12-month ($p<0.05$) intervals when baseline ratings were adjusted. Mueser et al[24] measured a statistically significant improvement ($p<0.05$) in overall engagement for the intervention group over time, which was sustained when measured after two years, post-intervention.

Conversely, Drake et al[11] and Mowbray et al[23] found that engagement in daily living activities and reduction in symptoms improved for both the intervention and comparison groups when measured at six and 12-month follow-ups ($p<0.05$) and at 18 months in the Drake et al[11] study ($p<0.05$). However, Latimer[19] did not find a

statistically significant improvement in this domain when measured at the end of the 12-month study.

Two out of the four medium-rated studies did not find any statistically significant improvements in overall engagement and reduction in symptoms.[2, 3] However, Drake et al[11] reported both improvements in overall engagement and a decline in symptom severity at 18 months ($p<0.05$). McGilloway and Donnelly[20] measured global well-being and found that participants reported a decrease in psychological distress 12 months after receiving the intervention.

Effects of vocational training on engagement in daily living activities
All five studies looking at the impact of vocational training on non-vocational outcomes measured improvement in engagement in daily living activities. One study was rated as high WoE and four were rated as medium WoE for this review. Four studies did not find a statistically significant improvement in this domain.[1, 6, 8, 26] Only one medium-weighted study[29] reported a statistically significant improvement in daily living activities for those receiving vocational training ($p<0.05$).

Effects of voluntary work and education on engagement in daily living activities
Two out of the five studies that looked at the effect of voluntary work and education measured impact on overall engagement. One study was rated as high WoE[22] and two studies were rated as medium WoE for this review.[18]

Mowbray et al[22] found that after adjusting for baseline levels those participants receiving the classroom and group support programme conditions showed a statistically significant increase in their ability to adjust to family situations, financial concerns and interpersonal issues($p<0.05$). Participants in the Isenwater et al[18] reported a decrease in their anxiety levels as a result of receiving support while studying.

Quality of life

Effect of integrated services on quality of life
All 11 studies evaluating the impact of integrated services on non-vocational outcomes looked at one or more dimensions related to quality of life. Six studies were rated as high[10, 19 , 21, 23, 24, 78] and five were rated as medium for this review.[2, 3 ,7, 10, 20]

Of the six pre-post test studies rated as having a high WoE two showed no statistically significant improvement in overall quality of life.[19, 24] Three studies reported a statistically significant improvement in overall life satisfaction[11,23] ($p<0.05$) and satisfaction with housing[11] ($p<0.05$). Two studies found that participants reported increased levels of confidence and motivation[21] and improvement in levels of hope.[78]

Only one out of the five pre-post test studies rated as medium measured and reported a statistically significant improvement in 'overall satisfaction' with quality of life[7] ($p<0.05$). The remaining four studies showed no improvement in quality of life measures.[2, 3, 10, 20]

Effect of vocational training on quality of life

Four of the five studies looking at the impact of vocational training on non-vocational outcomes measured the effect interventions had on one or more dimensions related to quality of life. One study was rated as high WoE[26] and three were rated as medium WoE for this review.[1, 6, 29]

Rogers et al[26] did not find an impact of participating in either the intervention or comparison group on quality of life. Of the three studies weighted as medium for this review, Accordino and Herbert[1] did not report their findings because of lack of validity with the measurement instrument they used. Browne[6] and Warner et al[29] did not find any significant group difference in terms of satisfaction with leisure or living situation.

Effect of work experience and education on quality of life

All five studies looking at the impact of work experience and education on non-vocational outcomes measured dimensions of quality of life. Two studies were rated as high[22, 25] and three were rated as medium for this review.[12, 15, 18]

The two studies rated as high WoE both measured an improvement in quality of life.[22, 25] Mowbray et al[22] found that although the intervention groups did report improvements in their perceived quality of life they did not consider themselves to be more empowered. Ratzlaff et al[25] found that participants reported higher levels of hope in their life after they had taken part in a work internship.

Of the three studies rated as medium, Ellison et al[12] did not measure any changes in participants' overall satisfaction with the quality of their life. However, Hagner et al[15] found that there there was a statistically significant increase ($p<0.05$) in the numbers of participants who were satisfied or very satisfied (between baseline and 24 months) with school life, progress towards personal goals and handling of problems. There was a non-statistically significant increase in satisfaction with physical health and a decrease (significance not given) in satisfaction with living situation. Isenwater et al[18] found that participants reported an increase in hope regarding their future work prospects once they had gained experience of learning in supported settings.

3.3.7 Summary of outcome studies

Self-esteem

- There is some evidence to suggest that integrated training and vocational interventions can be effective in improving self-esteem when measured at six months, but the findings are inconsistent across studies and at later follow-up periods.
- Voluntary work and supported education programmes which interview people indicate that they have an impact on participants' perception and self-reported measures of self-esteem.
- Only one study measured the impact of vocational training on self-esteem and was not shown to be statistically significant at the follow-up period of 24 months.

Social capital

- The impact of integrated services on social capital had mixed results, with some studies showing an improvement in the number of social contacts over time while others studies did not.
- Two studies that measured the impact of vocational training on participants' satisfaction with social contacts did not find any evidence of impact.
- Three studies looked at the effect of receiving supported education on social networks. While one study found that the number of social contacts did not increase as a result of taking part in an intervention, two studies found that people made friends through taking part.

Engagement in daily living

- Overall integrated services can be effective in improving people's ability to engage in daily living activities, in some cases for both the control and the intervention group.
- Four out of five studies evaluating the impact of vocational studies have not shown to be effective in improving overall engagement.
- Two studies evaluating supported education measured an increase in participants' ability to respond to stressful life incidences and reduced anxiety allowing participants to cope with the demands of studying.

Quality of life

- Just over half the studies (*n*=6) evaluating integrated services were shown to be effective in improving different aspects of quality of life. Six studies reported statistically significant improvements in participants' quality of life. However, five studies study showed no impact.
- Four out of five studies evaluating the impact of vocational studies have not shown to be effective in improving quality of life.
- Four out of five studies evaluating voluntary work and education had an impact on at least one aspect of quality of life.

3.4 Discussion: outcome evaluations

3.4.1 Findings from systematic reviews

The research review looked at the impact of training and vocational interventions on non-vocational outcomes. However, we did not address questions on the effectiveness of these interventions on vocational and employment-related outcomes because a number of reviews and systematic reviews had been conducted in this area. The systematic map identified three systematic reviews [33, 32, 50] that addressed questions on the effectiveness of supported employment and pre-vocational training programmes. The studies included in these reviews overlap to a great extent with the ones used in this research review.

The studies unanimously show that, as compared to any other vocational intervention, integrated services and supported employment programmes such

as the IPS was significantly effective in achieving employment-related outcomes. However, the systematic reviews also noted that there continue to be participants who did not gain employment for the duration of the studies included in the reviews.

The systematic reviews conducted by Crowther et al[50] and Moll et al[32] also supports the findings of this review. They note that vocational interventions such as IPS showed no effect on non-vocational outcomes such as self-esteem, social networks, quality of life[32] or on any clinical outcomes. [32, 50]

The reviews have not assessed the effect of other types of vocational interventions or education interventions on non-vocational outcomes.

3.4.2 Findings from the research review

Integrated services

The findings from the research review indicate that there are inconsistencies regarding whether integrated services improve non-vocational outcomes. Becker et al[3] found that changes in outcomes are not typically seen at the programme level as many clients do not become consistent workers over time.

Mowbray et al[23] suggest that 'there is little support for the hypothesis that supported employment has a generalized effect on other outcomes'. Latimer[19] did not find any improvement across all the non-vocational domains measured in his study either. This finding is attributed to the fact that the supported employment service started at the same time as the study and Latimer feels that a more mature programme could produce a larger difference between the groups. Both Bailey et al[2] and Drake et al[11] conclude that non-vocational outcomes may only be weakly related to vocational engagement or that clients need more time in jobs before non-vocational gains can be generalised to other domains.

Vocational training

The interventions groups under the heading of vocational training adopted similar recovery-orientated approaches (person-centred, strengths-based and socially inclusive). The reasons for not showing a clear improvement in non-vocational outcomes were briefly reported in the studies. Accordino and Herbert[1] found that there were no differences for any of the programmes evaluated nor could the authors identify if there were any common factors inherent in any of the programmes that could account for the outcomes. Browne[6] measured both reduction in mental health symptoms and quality of life but cautioned that results may have been because of a of selection bias, with participants with past work experience being more likely to be in the comparison group. In the study by Danley et al[8] the authors suggest that they had not expected to find any effect on social support or on symptoms but did not provide an explanation of why that might be. Rogers et al[26] considered that the efforts made to keep comparison group participants from dropping out may have mitigated the differences between comparison group and intervention group. Meanwhile Warner et al[29] concluded that the intervention group showed fewer

results compared to the comparison group because their mental health status was more 'stable' than the intervention group.

Work experience and education

Studies evaluating the impact of voluntary work and education were less likely to have a control group. Ellison et al[12], Hagner et al[15] and Ratzlaff et al[25] all state that it is difficult to tell if changes occurred because of the intervention, the passage of time or because of coinciding events. Isenwater et al[18] suggest that students might have only joined the course because their mental health had improved and this is what accounts for higher levels of engagement in the course. Mowbray et al[22] state that both intervention group and control group showed improvements over baseline, which raises questions about if they would have improved anyway, although overall improvements were greater in the intervention group.

3.5 Research synthesis: process evaluations

This section of the knowledge review includes the findings of the process evaluations identified from the systematic map. Process evaluations are evaluations of how an intervention has been implemented.

A synthesis of the evidence available to answer the research review question is presented.

The research review question is as follows:

What is the process of training and vocational interventions employing recovery approaches in community-based adult mental health services?

To answer this question we have conducted a synthesis of findings from a diverse range of study designs. The findings are based on studies we judged methodologically sound and which provide data on the delivery interventions employing recovery approaches. Studies were also grouped according to the three intervention types – integrated services, vocational training and voluntary work and education – and analysed by each recovery dimension.

3.5.1 Quality and relevance of process evaluations

All of the process evaluations included in the research review evaluated the delivery of training and vocational interventions that sought to improve vocational and/or non-vocational outcomes.

The WoE judgements (see Section 3.1.7) were based on overall soundness of the study in terms of internal methodological clarity coherence, and quality (WoE A), the appropriateness to this review of the methodology used to evaluate the intervention (WoE B) and the relevance of the study for answering the review question (WoE C).

Two of the nine studies were judged to be low on WoE A and one out of the nine studies were judged to be low on WoE C and were therefore given low WoE overall

(WoE D) and excluded from the research review. For the remaining six studies the overall WoE D was taken as an average of A, B or C. Three studies were rated as high and three were rated as medium for their overall WoE (WoE D).

Table 3.5: Weight of evidence (WoE) for process evaluations

Study	WoE A	WoE B	WoE C	Overall WoE D
Blitz and Mechanic (2006)[4]	Medium	Medium	Medium	Medium
Block (1992)[5]	Low	Low	Low	Low
Drake et al (2003)[9]	High	High	High	High
Gowdy et al (2004)[13]	Medium	Medium	Medium	Medium
Grove and Seebohm (2005)[14]	Medium	Medium	Medium	Medium
Harding et al (1987)[16]	Low	Medium	High	Low
Henry and Lucca (2005)[17]	High	High	High	High
Rogers et al (1997)[27]	Medium	Medium	Low	Low
SESAMI (2006)[78]	High	High	High	High

3.5.2 Characteristics of process evaluations

Six process evaluations met the inclusion criteria and were judged to be methodologically sound; they were published between 1992 and 2006. Four were conducted in the US (n=4) and two in the UK. All of the studies evaluated how training and vocational services with person-centred approaches are delivered and included a range of community-based training and vocational interventions that aimed to improve either vocational or non-vocational outcomes.

3.5.3 The process of training and vocational interventions employing recovery approaches, in community-based adult mental health services

Table 3.6: Recovery dimensions discussed in the process evaluations

	Recovery dimensions						
	Person-centred	Strengths-based	Holistic service	Flexible service (non-linear)	Peer support	User–practitioner relationship	Social inclusion
Integrated services							
Drake et al (2003)[9]	X	X	X	X			
Grove et al (2005)[58]	X	X	X	X	X	X	
SESAMI (2006)[78]	X	X	X	X		X	
Vocational training							
Blitz and Mechanic (2006)[4]	X	X	X	X			
Gowdy et al (2004)[13]	X	X	X	X		X	
Integrated and vocational training							
Henry and Lucca (2005)[17]	X	X	X	X	X	X	

Person-centred and strengths-based: 'Tailoring services to individual aims, aspirations and strengths'

Integrated services

All of the studies evaluating the process of delivering integrated services provide information from practitioners about how services are delivered to take account of the individual needs and strengths of people who use services. All three studies found that working closely with people who use services, listening to and understanding what they want leads to more effective vocational goal planning.[9, 58, 78] Drake et al[9] also found that in integrated services practitioners were more likely to work together to assist users in achieving their vocational goals. The employment support services evaluated by Grove et al[58] operated an individual case management system to ensure that support was tailored to meet the needs of each individual using the service. SESAMI[78] provided data from staff delivering training and vocational interventions which indicated that listening to and understanding people who use services was a core aspect of delivering person-centred services which are based on what users want to do, their strengths and not what practitioners think they 'should' do.

Vocational training

Both of the studies evaluating vocational training used person-centred and strengths-based approaches. The study by Blitz and Mechanic,[4] which aimed to explore the factors that may facilitate or hinder the supported employment programme, found that practitioners utilised users' existing records and other assessment tools to identify with the user what skills they might need to re-enter the workforce. Gowdy et al[13] aimed to identify which factors contributed to differences in competitive employment rates for adults with severe mental illness between high and low performing programmes. They found that high-performing services used explicit person-centred and strengths-based practices compared to services that did not. In high-performing sites you were more likely to find both staff and people who use services using goal-focused approaches. In high-performing sites staff discussed using the strengths model, had been on strengths training and considered the strengths perspective to be a positive influence on their practice and performance. In addition, all high-performing sites were much more likely to recognise consumers themselves as a positive factor in competitive employment performance than staff at comparison sites.

Integrated services and vocational training

Henry and Lucca[17] found that practitioners from both integrated services and vocational training-based interventions talked of the importance of individualised, person-centred approaches, matching jobs to consumer interests and strengths and emphasised the need to individualise interventions.

Holistic services: 'Linking with other aspects of life'

Integrated services

All three studies evaluating the impact of integrated services indicated that they support both vocational and non-vocational aspects of people's lives. Drake et al[9] talked about the need to address wider issues that might be causing a barrier to employment, such as interpersonal skills, family difficulties and transportation problems. Again they suggested that this was easier for integrated services where the vocational specialist, the mental health providers and the people who used services formed a single team that shared information frequently, to be certain that they developed and supported an holistic care plan. Grove et al[8] found that employment advisers supported people with financial and family circumstances. Advisers actively engaged with the difficulties regarding the benefit system and supporting people to obtain financial advice from the Citizens' Advice Bureau if required. Employment advisers would also work with a service user's partner or relative(s) and received positive feedback from carers about their involvement in this area. Practitioners in the SESAMI[78] study made a direct link between person-centred approaches and holistic ways of working. They suggested that by the very act of taking on board and going with what people who used services wanted, means that practitioners are likely to be working with all aspects of a person's life, not *just* their vocational goals.

Vocational training

Both of the studies evaluating the delivery of vocational training looked at how services linked with other aspects of a person's life. Blitz and Mechanic[4] found that if looking at re-entering employment can be considered within the wider context

of a person's life, then there is a better prospect of people who use services gaining and retaining employment. Job coaches actively considered how transportation, childcare and housing needs might be acting as barriers to gaining experience in the job market. Gowdy et al[13] found that users from high-performing sites were more likely to gain and retain employment when staff addressed users' wider fears about going back to work and how this might impact on other areas of their life, especially regarding the loss of benefits.

Integrated services and vocational training
Henry and Lucca[17] also found that both integrated services and vocational training services could not support vocational goals in isolation from looking at other parts of people's lives. Again, they found that the most salient issue for people who use services was financial concerns and loss of entitlements.

Flexible and non-linear services: 'Dealing with setbacks in mental health'

Integrated services
All of the studies evaluating integrated services looked at how services supported people when they had setbacks in their mental health. Integrated services evaluated by Drake et al[9] had less difficulty retaining user engagement in vocational services because vocational specialists were added to an existing team and provided outreach support, which included making routine efforts to re-engage users who had been hospitalised or experienced other difficulties. The study by Grove et al[58] found that employment advisers worked alongside clinicians to find ways to address any additional support needs. They also offered complimentary therapies such as acupuncture, reflexology, Reiki and aromatherapy services to support people's mental health well-being. However, SESAMI[78] found that only one practitioner reported on communicating with care coordinators if users raised issues regarding setbacks in their mental health problems.

Vocational training
Studies looking at vocational training did not work closely with clinical teams in the same way that integrated services do by adding employment specialists to existing clinical teams. However, Gowdy et al[13] found that services which had a higher success rate of supporting people to enter into competitive employment were more likely to work closely with therapists who supported the idea that working could benefit people's mental health. They drew a comparison to low-performing interventions where there was no mention of the importance of therapists' involvement or support with either vocational or non-vocational goals.

Integrated services and vocational training
Henry and Lucca[17] found that both integrated services and vocational training programmes valued but struggled to maintain good communication with clinicians when trying to support people when they experienced setbacks in their mental health. Overall they found that in both programmes a lack of service coordination made it difficult to provide flexible services.

Peer support: 'People who use services **supporting each other'**

Integrated services
Peer support was briefly mentioned in the study by Grove et al.[58] They reported that people who use services who had attended self-management courses reported a sense of relief and gained strength from hearing about other people's experiences of employment in the light of their mental health difficulties.

Integrated services and vocational training
Henry and Lucca[17] also found that beyond relationships with staff, users of services from both integrated services **and vocational training services** emphasised the importance of hearing about other people's experience of work placements, training and competitive employment and how this impacts on their mental health.

User–**practitioner relationship: Respect, responsibility and hope**

Respect: 'Working together'
Integrated services
Both the studies by Grove et al[58] and SESAMI[78] explored the user–practitioner relationship. People who used services in the Grove et al[58] study talked about feeling a sense of relief once they had made contact with an adviser who understood what they were going through. They stated that advisers helped to reduce fear regarding re-entering the workplace and that overall their relationships with advisers were extremely helpful and therapeutic. Practitioners in SESAMI[78] stated that accessible services with friendly and helpful staff, who took people who use services seriously, respected their viewpoints and worked with them were all essential ingredients to providing person-centred services.

Vocational services
Gowdy et al[13] found that the distinguishing feature between low-performing interventions and high-performing interventions was the organisational ethos of staff working in different sites. The attitudes of practitioners in high-performing sites were positive about people's abilities to enter into mainstream competitive employment despite mental health problems. They worked with people in a rapid way to achieve vocational goals. High-performing interventions operated top-down policies, whereby managers actively supported and encouraged their staff to deliver services which respected and valued people who use services.

Integrated services and vocational training
Henry and Lucca[17] found that users and practitioners from both services drew attention to the importance of trusting and respectful partnerships between providers and consumers. They recognised that building relationships take time and resources to develop. Both users and practitioner also felt that high staff turnover disrupted the development of supportive mutual relationships.

Responsibility: 'Encouraging people who use services **to take responsibility for their actions and progress'**

Integrated services
Only SESAMI[78] looked at how practitioners support people who use services through their vocational process. They found that practitioners talked about the importance of users working at their own pace and that practitioners should not apply any pressure because this negates the message that the user is in control and can decide at what pace they wish to proceed.

Hope: 'Giving people the message that they can achieve their goals'

Integrated services
Grove et al[58] found that the proactive attitude of employment advisers and the competent way in which they worked with people who use services to address the support they might need to re-enter the workplace put users 'at ease' and made them feel much more relaxed and confident about their own abilities to succeed. SESAMI[78] found that practitioners considered working with users to build their confidence: being a reliable contact and source of support and having a genuine commitment and enthusiasm for working with users on their vocational pathway was the strongest message they could give to users that they believed they could achieve their goals.

Vocational training
The findings from Gowdy et al[13] showed that in low-performing sites, where consumers were less likely to gain competitive paid employment, programme leaders conveyed either disbelief in consumers' ability to work or displayed a limited view of who was able to work compared to the 'can do' attitudes of high-performing sites. The authors linked this to the strengths-based model adopted in high-performing sites and the positive attitude of staff when addressing any barriers to work that may be presented by people who use services.

Social inclusion: 'Linking with mainstream services'

None of the studies included in this section explicitly talked about how they linked in with mainstream services.

3.5.4 Summary of process studies

Person-centred and strengths-based approaches

- Both types of interventions, integrated services and vocational training used person-centred approaches and strengths-based modelling. They used these approaches to work with people who use services to develop and support vocational goal planning. All studies emphasised the importance and the need to deliver services that were individualised to the interests of users.

Holistic services

- Integrated services and vocational training services support the wider aspects of people's lives. The most common issue that required practitioner support was negotiating the benefit system and addressing concerns about loss of entitlements.

Flexible and non-linear services

- Five out of six studies looked at how services can support people when they experience setbacks in their mental health.
- One study evaluating the delivery of integrated services reported that it was easier to re-engage people who used services if they experienced a relapse in their mental health because communication between employment specialists and clinical teams was easier.
- Another study evaluating vocational training also reported that it was easier to support people who used services in paid work when clinical teams held the same beliefs about the benefits of working.
- However, Henry and Lucca[17] found that in both types of intervention there were difficulties between employment specialists and clinical teams working and communicating together, and that the focus was on greater service coordination and continuity of care which led to providing flexible services.

Peer support

- Only two studies looked at the ways in which people who use services could support one another. They found that peer support could be a beneficial source of increasing users' hope and belief in their own vocational processes.

User–practitioner relationship

Respect

- Both types of interventions rely on positive working relationships between people who use services and practitioners based on trust and respect to facilitate the vocational process.

Responsibility

- Only one study (SESAMI)[78] talked about a practitioner's role in encouraging services users to take responsibility for their actions. Again, they found that working with and at the user's pace was a positive way to approach this issue.

Hope

- Two evaluations of integrated services and one evaluation of vocational training looked at how practitioners could give people who use services the message that they could achieve their goals. They talked about the importance of practitioner attitudes. Practitioners who were confident in users' abilities, who worked with users in positive, problem-solving ways and were able to provide a reliable source

of support were all examples of how practitioners could give people a message of hope through their vocational journey.

3.6 Discussion: process evaluations

3.6.1 Systematic review

A systematic review by Kirsh et al[31] identified barriers and facilitators to employment. They identified the following facilitators to employment: focus on employment, vocational specialists as part of a team or programme, ongoing support, job matching and attending to a client's needs, rapid placement, problem-solving approach to daily living, pay for work, team approach, support and education for employers and co-workers, a range of accessible and available services. Moll et al,[32] in their systematic review, identify issues in work performance, clients' dissatisfaction with the job, interpersonal problems and poor management of illness as barriers to employment as barriers to employment.

3.6.2 Findings from the process evaluations

Integrated services

The three studies looking at the process of delivering integrated services placed their focus in different areas. Drake et al[9] are particularly interested in the importance of breaking down professional barriers to be able to support people in re-entering the workforce. They argue that integrated services provide a better standard of service, particularly for users with multiple needs. They state that multi-disciplinary teams have a greater ability to engage with people who use services and that there are more opportunities for different mental health disciplines (clinical, social care and employment advisers) to communicate with each other within the mental health system. In addition, they consider the development of effective vocational services as enhancing the recovery process because it provides a wider focus in which to view users' lives.

Grove and Seebohm[14] found that to support people effectively, timely and quick responses from employment support workers is essential. They also found that in many cases, working with employers to increase awareness about the impact of mental health is as important as supporting people who use services. They also found that working with people holistically, to look at all aspects of their lives, and to utilise complimentary therapies and other self-management courses promoted positive responses from users. The study by SESAMI[78] also considers that combining models of support employment with psychological preparation, such as confidence building and anxiety management, is another way forward for training and vocational interventions. In addition, they consider that services would benefit from incorporating financial information and links with wider networks to strengthen the services they already provide. They also highlight the lack of representation of people from the black and minority ethnic groups who are not being currently addressed by mainstream mental health employment services.

Vocational training

Blitz and Mechanic[4] conclude that they have identified important supported employment strategies, such as evaluation, training and removal of structural barriers, as well as recognising that services must be tailored to individual users of services. The study by Gowdy et al[13] went further as they were able to identify examples of organisational best practice for supporting people to effectively gain paid competitive employment. They found that the role of administrators in developing an organisational culture that is supportive of work and the role of case managers in pursuing work-related goals for themselves and services was an important factor in the success of a programme. They also identified that effective vocational programmes were more likely to have frequent team meetings and take a teamwork approach, have a systematic way of informing people who use services about their programme and focus on work-related goals.

Integrated services and vocational training

Henry and Lucca[17] critically reflected on their findings and stated that while advocating person-centred approaches is central to providing effective employment services, choice can still be constrained to a limited range of options within a vocational model and can therefore not be a 'true' choice. Thus they advocate that the widest choices available are made to people and that examining the personal and financial implications for each individual as they move towards employment should be a central part of any training and vocational intervention. They also stated that while integrated services are a key feature of evidence-based employment services, practitioner attitudes can hinder effective communication, and professional hierarchies within social care and clinical teams regarding the differing views of treatment versus rehabilitation versus recovery may undermine efforts to provide integrated services. They also advocate that trained benefit counsellors are available to all training and vocational services.

3.6.3 Diversity issues

The studies did not discuss racism, sexism, ageism and other oppressive factors that can affect the recovery process and how services and models of recovery are addressing these issues. Nor was there much ethnographic research exploring practitioners' and users' perspectives and experiences of recovery approaches in the delivery of training and vocational services.

3.7 Conclusion

The research review examined the research evidence on the impact of recovery-orientated training and vocational interventions on non-vocational outcomes.

Of the 21 outcome studies that met the inclusion criteria and were judged to be methodologically sound, little evidence was provided to suggest that different types of training and vocational interventions lead to differences in non-vocational outcomes.

The research evidence was not conclusive, with predominantly inconsistent findings of the impact of training and vocational interventions on self-esteem, social capital, engagement in daily living activities and quality of life (see Section 3.3.7).

Although many studies reported an effect of an intervention, there were many other studies reporting no evidence of effect. The only areas where there seemed to be consistent effects was: voluntary work and supported education programmes impacting on participants' self-reports of improved self-esteem; supported education helping participants' ability to cope with the stress of studying; most studies on integrated services and voluntary work and education showing an improvement in quality of life; and most studies on integrated services showing an improvement in engagement in daily living activities and reduction in mental health symptoms

The findings indicate that although training and vocational interventions are shown to have an impact on vocational engagement, vocational engagement is weakly related to non-vocational outcomes. It is likely that programme effects on vocational and non-vocational outcomes are specific to the content and delivery of the programme. Another possibility is that people who use services need more time in employment, training or education before vocational gains can be generalised to other non-vocational domains.

The six process evaluations that met the inclusion criteria and were judged to be methodologically sound identified a wide range of components of recovery approaches to vocational interventions.

These studies were rich in describing the different recovery dimensions but they provided little detail of the mechanisms by which these are achieved or what features would differentiate successful and non-successful services. Nor did they give attention to user issues or racism, sexism, ageism and other oppressive factors that are beyond yet can interact with health issues.

4 Practice survey

4.1 Aims and objectives

The practice survey asked:

> How are recovery-based approaches being used by community-based adult mental health training and vocational services in the UK?

The aim of the practice survey was to explore the ways in which the use of recovery-based approaches in community-based adult mental health services can support people in accessing work, education and other forms of meaningful occupation. Data used to answer this question was sought from an online and postal survey and in-depth interviews with practitioners from the UK.

4.2 Survey method

4.2.1 Survey design

A survey of vocational and training services being delivered in community-based adult mental health services in England, Wales and Northern Ireland was designed to identify any current approaches to recovery that practitioners may be adopting based on the conceptual model outlined below.

Person-centred: the extent to which training and vocational services are placing people who use services at the centre of service provision.

Strengths-based: the extent to which practitioners are working with people who use services to identify and build on their individual strengths and resources.

Holistic services: the extent to which training and vocational services look at the wider aspects of users' lives.

Flexible and non-linear services: the extent to which services are able to support users in flexible and non-linear ways, particularly when people experience setbacks in their mental health.

Respect: the extent to which practitioners work with people who use services with honesty, openness, trustworthy attitudes and behaviours.

Responsibility: the extent to which practitioners foster independence not dependence in their relationships with people who use services and encourage users to take responsibility for their actions and progress.

Hope: the extent to which practitioners work with people who use services to provide messages of hope and believe that they can achieve their goals.

Social inclusion: the extent to which practitioners are linking in with mainstream services in the wider community.

See Section 1.2.1 for background information on where the use of these terms originated.

4.2.1.1 Online and postal questionnaire

An online and postal questionnaire was designed with input from the Project Advisory Group and project consultant. The questionnaire included both closed and open-ended questions, with additional space for respondents to expand on their answers. Respondents were asked to describe the type of training and vocational services they provided and the recovery approaches they adopted, if any. The questionnaire is provided in the technical appendix. web link

4.2.1.2 In-depth interviews

The interview was designed to expand on the questions posed in the questionnaire regarding the nature and breadth of recovery dimensions present in training and vocational services delivered in the UK. The survey questions were sent to the project consultant and SCIE for approval before interviews took place. The interview schedule is provided in the technical appendix. web link

4.2.2 Sampling

The Project Advisory Group and the project consultant also played a critical role in advising on the variations in types of informant for the practice survey and the basis of sampling of respondents.

The sampling frame comprised of two approaches: (i) a geographical sample of routine mental health practice; and (ii) a key contact sample of known community-based mental health services across England, Wales and Northern Ireland.

Routine practice

We contacted:

- local implementation team leads in each primary care trust
- commissioners of mental health services by regional health authorities and local implementation teams
- CSIPs.

Each key contact was asked to distribute an email that contained information about and how to complete the practice survey.

Key contact sample
This sample was devised from key organisations brought to our attention from the project lead at SCIE, the Project Advisory Group and the project consultant. Further organisations were also identified from internet searching.

For both approaches, further informants were identified by asking those who responded to identify other contacts. An email that included an electronic version of the questionnaire together with a covering letter, information sheet about the project and a link to the online survey was sent to potential respondents in August 2007. A postal version of the email with a freepost return address label, was also sent to potential respondents in August 2007. Those who had not responded within four weeks were sent a reminder, including a second copy of the questionnaire, by email. The deadline for responses was finally closed in October 2007.

4.2.3 Response rate

4.2.3.1 Online and postal questionnaire

Approximately 300 practitioners were invited to take part in the survey, and there were 94 responses (a response rate of 31 per cent). Three cases were excluded from the analysis – two organisations which primarily provided services for those suffering from disabilities other than mental health (Asperger's syndrome/autism and acquired brain injury) and one GP practice. Of the remaining 91 questionnaires, 22 were subsequently excluded because there was too much missing data. The analysis is therefore based on 69 valid questionnaires.

4.2.3.2 In-depth interviews

Thirty-nine of the 69 questionnaire respondents agreed to be contacted to take part in in-depth interviews. Twenty potential participants were contacted with a total of 13 respondents taking part in telephone interviews.

4.3 Data analysis

4.3.1 Online and postal questionnaire

Quantitative and qualitative data from the questionnaires was downloaded from the anonymous online survey database in an excel format. Quantitative and qualitative data was recoded and analysed by one researcher and verified by a second researcher. Quantitative data was analysed using descriptive statistics. Qualitative data was analysed thematically using the survey questions as the basis for categorising the replies given.

4.3.2 In-depth interviews

With the participants' permission the interviews were digitally voice recorded and fully transcribed. The transcripts were analysed thematically according to the recovery dimensions outlined in Section 4.2.1. Individual transcripts were read and re-read to take account of and group all the data according to the recovery dimensions. The data was then compared across transcripts in an iterative process to ensure that all the data were accounted for and to identify convergent and divergent themes. The main themes relating to participants' experiences of adopting recovery-orientated approaches are provided in Section 4.4.

4.4 Survey results

4.4.1 Types of training and vocational services

The community-based training and vocational services (*n*=69) that took part in the practice survey ranged from sheltered workshops, supported education to the IPS model of supported employment. The vast majority of participants identified their agencies as voluntary/not-for profit. Other types of organisations included social enterprises, user/peer/self-advocacy group, a commercial business and a further/higher education institution. Table 4.1 gives a breakdown of aims undertaken by training and vocational services that took part in the survey.

Table 4.1: Aims of the service

Service supports people:	*n*	%
to enter mainstream employment	67	99
once they are in mainstream employment	48	71
to enter alternative forms of employment	48	71
once they are in alternative forms of employment	35	52
to take up education courses	58	85
once they are undertaking education	43	63
to take up volunteering	58	85
once they have taken up volunteering	41	60
to take up arts or other creative activity	37	54
once they have taken up arts or other creative activity	27	40
to take up other forms of vocational activity	30	44
once they have taken up other forms of vocational activity	23	34
other	6	8

As can be seen from Table 4.1, the vast majority of organisations supported people to enter mainstream employment, with a large number (85 per cent) also helping their users to access education courses or volunteering. More organisations supported people to *enter* employment, education, volunteering or other activities than provided support once the service user had begun the activity; the difference between organisations that provided pre-activity support rather than post-activity support was 20 per cent on average.

4.4.2 Target population of training and vocational services

The majority of training and vocational support that took part in this practice survey targeted all people who use mental health services. Less than two thirds of participants (*n*=41) said that their service specifically targeted subgroups of users

of mental health services but did not specify who. Seven stated that they targeted those who were on a care programme approach (CPA) (in two cases enhanced CPA), while five said that they targeted those with severe and/or enduring mental health. An additional six stated that users should be in receipt of secondary services. One said that those with 'mild to moderate anxiety and depression' were targeted, while another identified people with 'harmful levels of stress, common and severe enduring mental ill "health", drug and alcohol issues and eating disorders'.

Ninety-three per cent of participants (*n*=64) said that their organisation provided support to all ethnic groups. Only one specified that the service was aimed at one specific group ('African, African Caribbean and Black dual heritage service users'). A large number – 88 per cent – offered the service to both men and women, while in four cases, it was offered exclusively to women. No one said that it was only offered to men. Several respondents said that their service was offered to working-age people aged 16 or 18-65. However, there is missing data in four cases.

Further data from the practice survey can be found in the technical appendix.

4.4.3 Recovery-orientated approaches

Person-centred and strengths-based: 'Tailoring services to individual aims, aspirations and strengths'

Organisations described different ways in which they helped users to recognise and build on strengths. Over half reported that the process involved meeting with users personally in order to help them reflect on their achievements and experiences and to identify and recognise strengths and skills. There was a strong emphasis on being positive when working with users. A small number highlighted the importance of building trust between practitioners and users in order to work within 'strengths-based' approaches. A few participants also talked about developing users' self-confidence through encouragement, confidence building, motivation and empathy. One respondent mentioned that there were courses users could attend specifically for this purpose. Another approach to recognising and building on strengths involved providing users with short-term vocational opportunities or training (four organisations). The approach or model used identified by a few practitioners included: coaching techniques (four), recovery principles/approach (two) and cognitive behavioural therapy framework (two). The principle behind using models is to be more explicit about the practice being adopted. Models such as coaching techniques which use neurolinguistic programming (NLP) and elements of cognitive behavioural therapy is the belief that anybody can make changes about how they see themselves, such as having strengths, and this can lead to positive changes in behaviour, such as working towards vocational goals.

Holistic services: 'Linking with other aspects of life'

Participants were asked, 'How does the support provided by your service link with other aspects of your life?'. Examples of non-vocational issues such as housing, health and interest were given. Around a quarter responded by saying that their main focus was on employment and/or that they referred or signposted users to

the appropriate service or agency if the need was identified, or informed their care coordinator. Around the same proportion of organisations did provide some support around non-vocational issues, but also signposted users as necessary.

Several respondents identified the approach they used as 'holistic', where 'all areas of a service user's life' were addressed; sometimes this was within a 'care' plan. A few said that specific facets of their service were designed to address other aspects of users' lives, such as employing community Connexions advisers or running an outreach service. Others described how they developed links with external agencies in order to support people who use services, for example by encouraging visits. A small number participated in review meetings with mental health teams or other external meetings where appropriate. Seven said that contact between users and support workers helped this process, as needs emerged during meetings or review sessions.

Practice example 1: Community projects

The aim of a project in Plymouth is to enhance the social and economic well-being of its local communities by promoting choice and opportunity for individuals. One way they approach this is by offering an employment, education or training support service for anybody with mental health problems. They operate an open access policy whereby an individual or anyone supporting an individual can contact the service to set up an appointment to speak to an employment adviser.

The service provides one-to-one support, information and advice about employment and training opportunities and practical help applying for jobs. This includes supporting individuals to gain training in work preparation skills, helping people to access mainstream services with the eventual goal of employment or work type activity, providing practical help in applying for jobs, acting as a resource centre and link between the individual and various schemes and providing continued support for the individual throughout the process.

Through one-to-one meetings with an employment adviser, the service works with people to set and agree individual goals and an action plan. The service supports other aspects of a person's life by setting up networks and groups that can address issues such as assertiveness, anxiety management and making healthy lifestyle choices. The aim is to work with people on a continuum, from education, training, self-management, voluntary work to full-time employment, whereby people can opt in and out of a service depending on what is best for them at any point in time. People who use services are encouraged to support each other through attending groups and by working at the service as volunteers or as staff on permitted work. Links with care coordinators and GPs are encouraged from the 'top down' to maintain useful and timely communication when additional support is required.

Flexible and non-linear services: 'Dealing with setbacks in mental health'

Around half the organisations said that if a person who used services suffered a setback in their mental health, they would offer support in some way. For example, they would offer more intensive one-on-one support, encourage 'challenging unhelpful thinking', 'listen compassionately', arrange extra visits as required, liaise with the employer/family as appropriate and/or be flexible.

In many services support could be altered in some way to accommodate users' changing needs. One organisation had created a post specifically to help users at this stage. A small number explained that they would aim to 'normalise' mental health difficulties. Several said that they liaised with mental health services or the user's care coordinator, or considered doing this, as well as providing support themselves. There was an emphasis here on 'joined-up services' and 'continuity of care'. Some were part of community mental health teams, and so provided this support 'in-house'. However, around a third referred users to mental health services or GPs, or arranged appropriate therapeutic intervention, particularly if the setback was severe.

A few responses to this question centred on anticipating setbacks or relapse prevention. These participants reported that there was monitoring and regular discussions of progress, with some organisations working with people who use services to recognise their symptoms and potential relapses. In a few organisations, services were 'paused' or 'suspended' at this time, and users were 'allowed to take a break' as required, with some operating an 'open-door philosophy' whereby placements were kept open.

Peer support: 'People who use services **supporting each other'**

Responses to this issue were fairly diverse. Around a fifth reported that people who used services did not support each other within their service, with some signposting on to outside drop-in groups or befriending services. The reasons cited for not providing this internally included the existence of established local groups and the 'one-on-one' nature of the service. However, a small number were planning to develop peer support initiatives. It is unclear from the survey respondents whether the structure of these organisations inhibited users from supporting each other or whether peer support was simply not facilitated or encouraged.

Over a third of organisations provided some kind of facility or service for this purpose such as peer support groups, drop-ins, peer mentoring, service user forums, befriending schemes or job clubs.

In about 20 per cent of organisations, people who used services came into contact with each other and formed natural supports through engaging with the service, for example in organisations where users worked together in a sheltered workshop or in day services.

Another way in which people who used services provided support to one another, described by a fifth of organisations, was through role modelling. This was either through employing staff or volunteers with mental health problems or a history

of mental illness, or by providing case studies of 'success stories' from other users. In some of these cases, there was no actual contact between users, while in other organisations former users returned to give talks to current users.

Regardless of the method in which people who used services supported each other, support evidently extended to users' lives outside of the organisation.

Respect: 'Working together'

Many practitioners talked about their attitudes towards people who use services and how they treated them: with respect, compassion and understanding, being accepting and non-judgemental, and being open and honest. One had its own 'respect policy'. Others talked about a 'can do' approach and encouragement – "enabling hope!".

Ten practitioners explained that the service, including any 'ground rules', was clearly explained to users before they started receiving services, so that there were "clearly defined roles and responsibilities". A similar number of participants mentioned policies, staff training, employing users as staff. Another method identified by participants was listening to users. This could be asking for their opinions and feedback, listening to them in individual meetings or through user forums. Ten indicated that regular reviews helped with this process with one organisation administering 'twice yearly satisfaction surveys'.

A few others stressed the importance of the relationship between the service user and support worker, and described the benefits of 'working together' and 'therapeutic relationships. Other ways of developing constructive relationships were through valuing skills and praise; identifying and meeting users' needs; 'leading by example'; dealing with any problems, potential conflict or derogatory comments; and a general organisational ethos that supported building relationships with users.

Responsibility: 'Encouraging people who use services to take responsibility for their actions and progress'

A large number of practitioners said that people who used services were involved in developing their action plans or that there was joint goal setting. Users' agreement to the plans, and regular reflection or review was also raised. In some cases, users were asked to sign documents to encourage a sense of 'ownership'. There was an emphasis on responsibility lying with the service user. Several participants explained that the onus was on the user to achieve their goals, with staff being there to guide and provide support as and when it was needed.

The users' *choice* was a central concept and an emphasis on users' willingness to attend and take part in non-compulsory services. The focus was placed on staff to not 'do things' for users but 'with' people and to move away from seeing users as 'victims' of mental health problems and circumstances. In some organisations this was a gradual process, whereas in others service user responsibility and 'independence' was expected from the beginning.

Hope: 'Giving people the message that they can achieve their goals'

There were a few main ways in which organisations gave people who used services the message that they could achieve their goals. The first involved setting realistic goals, which could be broken down into 'bite-size' or 'manageable' steps, termed by one as a 'stepping-stone approach'. Acknowledging achievements and 'celebrating success' was equally as important. Looking at and building on past successes was part of this process.

The extent and scale of the outcome achieved was not the most important consideration. Practitioners were more interested in celebrating any successes made and defined by the service user that could encourage a sense of hope in their lives.

Positive attitudes and a 'can do' approach was central to this. Confidence building, encouragement, hope and 'constant praise' were highlighted as approaches that worked well. Practitioners talked about 'believing' in each service user's potential and looked at them as a person, reinforcing positive changes in each person's process.

The final way in which services gave people who used services the message that they could achieve their goals was by using success stories or role models, either from other users or staff.

Practice example 2: IPS model

The IPS service run in South Essex provides services to many of the urban areas outside the fringe of eastern London, particularly Southend, Thurrock and Basildon. The IPS approach is based on the premise that anyone wanting to work has the best chance of success if their aims and ambitions are taken at face value. Professional standards of confidentiality are maintained and practitioners are honest about dealing with any mental health setbacks or barriers to employment that helps people who use services to trust the support of the practitioners.

The service can be tailored to support the particular aims and aspirations of each individual service user in terms of the type of support required, the timing of the support, the gender of the work and other needs as defined by the service user. Employment advisers often work in partnership with the occupational therapists in the team to provide assessment and a programme to help people identify their own goals, particularly if these are very unclear. The vocational services are part of the social inclusion strategy of the trust. The service is also developing links to arts and leisure, spirituality and cultural support. When people experience setbacks in their mental health employment advisers link support for the individual with other members of the multi-disciplinary team, such as consultant psychiatrists, community psychiatric nurses, social workers and the psychology service, so that each person is given time and treatment options to recovery while still being supported by the vocational services.

Social inclusion: 'Linking with mainstream services'

Most organisations maintained links through 'partnership working' or 'networking'. Some were part of networks or an umbrella organisation.

A small number said they had a 'close working relationship' with particular agencies. Some invited representatives from other organisations to give talks. In a quarter of cases, organisations maintained links through the referral process: either receiving referrals, making referrals or supporting people who used services to access services, groups or activities.

A similar proportion took part in community activities, forums or other events such as job fairs, fundraising events, linking with local art galleries. A couple shared their premises with other services that helped to build links. This organisation described the benefits of using offices in the community.

Two proactively maintained links through personal contact, through 'community link specialists' or having named contacts. Another two mentioned that press coverage helped to raise their profile in the community.

4.4.4 Obstacles and barriers

Nearly half of participants said that a lack of funding or resources was a problem. In particular, issues around irregular or short-term funding, the impact on eligibility criteria, accessing training and staffing levels were identified. Linked with this, several people who used services mentioned that there was not enough time to do what they needed to do, and a couple said that they had to take on other services' roles to ensure that users were sufficiently supported.

Stigma or prejudice was another major obstacle. Respondents reported stigma among the public, the local community, employers and other mental health and non-mental health professionals. Fear, poor attitudes, or a lack of understanding/awareness was particularly a problem among employers, and some organisations found it difficult to arrange work placements because of this. One said that voluntary work was always favoured over paid employment by employers because they did not believe that people who used services could work.

In relation to this, six practitioners thought other health professionals' attitudes towards employment were problematic. Specifically, they felt that the medical model pre-dominated people's mindsets and that there was not enough recognition of the benefits of employment for those with mental illness.

There were further problems with professionals, such as lack of communication among professionals 'leading to a breakdown in care and support' and lack of understanding of the service. Barriers were also identified at a macro level, with 'constant structural changes' in the NHS and social services, and changing government priorities. Seven practitioners identified a lack of staff within the service, high staff turnover or lack of expertise within staff.

Another fairly big obstacle related to people who use services themselves. A number of problems were identified:

- distrust of users towards the service and professionals due to bad experiences
- a lack of self-belief in relation to working and low self-confidence
- fear after a long absence from the job market
- the effects of psychiatric medication
- lack of engagement and motivation
- job retention due to sick leave.

Practitioners provided some information about the barriers services users faced. The biggest issue cited was users' belief in their ability and a lack of confidence regarding re-entering the workforce in the face of mental health problems. This was also coupled by fears about support required if they did get a job, including the impact of medication, lack of motivation and engagement in work if they experienced periods of difficult mental health and losing their job if they needed to be signed off sick.

Just over a quarter of participants pointed to problems caused by the benefits system, often referred to as 'the benefits trap'. The inflexibility of the welfare benefits system was seen as penalising rather than encouraging people who use services back into work.

Other problems identified by a small number of practitioners included:

- a lack of job opportunities/employment links in the local area
- poor local transport
- bureaucracy
- collecting outcome data
- irregular referral patterns.

4.5 In-depth interviews

4.5.1 Interview participants

Thirteen people agreed to take part in telephone interviews. The majority of participants interviewed were employed by the NHS (*n*=7). Of the remaining six participants, three worked for the voluntary/not-for-profit sector, three worked for the local authority, two of which were from social services, and the other worked at a local college. More women (*n*=9) than men took part (*n*=4), and included both front-line practitioners (*n*=9) and practice managers (*n*=4).

4.5.2 Recovery dimensions

Person-centred and strengths-based: 'Tailoring services to individual aims, aspirations and strengths'

Practitioners discussed the importance of being able to provide a service that focused exclusively on the aims and aspirations of individual users of services. Many described how, until this point of contact, a person may not have had an opportunity to discuss

what they may want to do with their life following a mental health diagnosis. Some practitioners stressed that their work did not involve having a 'stock of jobs on the shelf' to try and fit the service user into, but that taking an individual approach meant looking at what each person wanted to do and how they wanted to do it. This is summed up by three practitioners, who stated the following:

> 'It's very much down to the individual, and what that person wants to do.' (NHS, practitioner)

> 'We help the client find solutions, we don't say this is where you should be working … we help them with their journey.' (social services, practitioner)

> 'It is, it's a very individualised service so we agree with that individual, sometimes it could just be saying "we're here if you experience a wobbly time, come and find us", that would be one end of it; the other spectrum would be if somebody needed a one-to-one weekly meeting. It changes and fluctuates, so at the start of the year or exam time that could be a particularly difficult time so we would offer more support and then reduce it down when things are hopefully ticking on ok.' (local college, practitioner)

A few organisations were currently in the process of developing their service with the remit of becoming 'more person-centred'. They aimed to do this by bringing on board 'employment specialists' who could work solely with people who use services to achieve vocational goals. Others had already obtained funding to do this and were looking to expand the number of employment specialists already in post. Others talked about having been part of setting up the service to ensure that it could be responsive to the individual needs of users.

One of the defining features of a person-centred service is the one-to-one relationship between user and practitioner. Building relationships with people who use services included getting to know who the person was, where they were in their recovery process, clarifying what skills and interests they had, what they might like to do in the future and what support they may need. Although, this 'getting to know you' phase was often based on profiling techniques, assessment forms or other recording methods, practitioners talked about moving away from formal procedures in order to have a 'real' conversation with people.

> 'You gauge on your first meeting whether going in with a form is ok … often I just push the paper away and focus on the person and just chat with them.' (social services, practitioner)

Other practitioners talked about moving away from an extensive period of assessing 'readiness' to pursue education or employment goals. One practitioner stated:

> 'People can just be supported to get back into work, as soon as possible, from there you can know from the real scenario what the issues are for that person.' (NHS, manager)

The idea being that once a person has been referred to an employment service the aim is to focus on the person and their occupational aspirations. However, in some cases practitioners highlighted users who, even though they had been referred to vocational services, felt they were unable to focus on 'what they are good at', that they had been demoralised by the system and that looking at their individual strengths was not something that came to them easily.

Practitioners outlined the different ways they approached this scenario. For the majority of practitioners interviewed it would simply be a matter of time and they would continue to work with someone in a sensitive and reflective manner until that person was ready to make progress with entering mainstream employment or education. Others talked about presenting the idea of volunteering, part-time work, or short-term training courses as a way for someone to obtain work experience, gain confidence and skills before moving on to competitive paid employment. Some practitioners resisted the idea of volunteering as a step to work or being used exclusively as an indicator of work readiness, stating that a person may not enjoy, or get bored with, volunteering, but that did not mean that they were not capable of other types of work. Overall, aiming to deliver services within a person-centred framework was considered to be the determining factor in helping people who used services identify, find and continue with meaningful occupations.

Holistic services: 'Linking with other aspects of life'

Although the main focus of services was employment, education or training, working closely with users often provided an opportunity to explore other aspects of a person's life that might be of benefit to their overall well-being. In many cases practitioners worked with users to address housing, health or financial matters *before* looking at vocational goals.

> 'If you see the client twice a week you begin to get an idea of what else the client might benefit from and you can actually help the client by discussing it with them.' (NHS, practitioner)

> 'Sometimes we get more involved in ensuring a person gets access to other services, such as a carer's assessment or getting GPs involved.' (social services, practitioner)

Providing holistic services was mostly done through signposting, that is, informing people about relevant services of interest to them in their local area or referring people to specific services. Signposting was a commonly cited practice, forming part of an overall service package and considered fairly straightforward. More problems arose when individual practitioners wanted to engage in referral or service user review processes. Some practitioners talked about encountering difficulties communicating with care coordinators and linking in with care plans and CPA meetings.

> '... it is very frustrating that you don't get very strong dialogue between us all ... it's very rare that I would be invited to a CPA meeting.' (NHS, practitioner)

Various practitioners discussed their role as an advocacy one, ensuring that people who used services received the services they were entitled to. This appeared to be of particular relevance when users experienced setbacks in their mental health.

Flexible and non-linear services: 'Dealing with setbacks in mental health'

Responses to the questionnaire indicated that services have a number of ways in which they could support people who use services if they experienced setbacks in their mental health. We asked practitioners to expand on this in the context of their service and what might stop this from being happening.

We found that the way in which services were set up and organised had an impact. Some practitioners talked about working closely with mental health teams, sharing the same office and working together to support an individual.

For example:

> 'If the employment specialist is working with someone who goes back into a period of being not very well, they can go and talk to the care coordinator and discuss any issues.' (NHS, practitioner)

> 'If someone becomes ill when I am working with them, because I work so closely with the team, then I can share that information quite easily, and they can actually engage. A care coordinator might not see a person that regularly, if they are receiving other service but they can if they are having a relapse.' (NHS, practitioner)

For others, the structure of their service was not organised in a way that facilitated straightforward communication:

> 'Everything needs to get linked up, but that isn't happening … often community psychiatric nurses discharge a client from their care but they are still working with an employment activity worker, so they'd need to try and get them seen again if they become unwell.' (NHS, manager)

Practitioners who were seen as part of someone's care team appeared to be able to provide more specific employment support to someone when they experienced setbacks in their mental health than those who were less involved. Emphasis was placed on being able to provide continuity of care:

> 'We've supported individuals to go to work where they have been facing sectioned, they've agreed to go to hospital and we've supported them from the ward. The view of the consulting clinician is, if they continue with something familiar then they can often recover from a relapse a bit quicker, that's the general view.' (NHS, practitioner)

Relapses in mental health were not considered to be a hindrance to continuing with employment, training or education, but simply a matter of something to 'look out for' and to be 'worked around'. Working with people who used services to

identify triggers that could lead to a relapse and understanding patterns or cycles in a person's mental health status was something that practitioners valued and attempted to tackle, but there appeared to be less formal ways that this could be integrated into service provision other than flagging it as an issue with users.

Peer support: 'People who use services supporting each other'

The responses to the questionnaire indicated that there were two main ways in which services users could support each other: either through informal means, such as friendships and social networks or more formal methods such as organised groups, peer support initiatives and role modeling schemes.

Interviewees indicated that services where users did come into contact with each other and form friendships that they, the practitioners, did not try and 'make this happen', but that the onus was on users to decide whether they wanted to form natural supports organically. One practitioner expressed that one way of encouraging peer support was to try and organise social events between users to foster friendships and support between them. However, this is now considered an out-dated approach to peer support. The current belief is that it is more empowering for users to decide for themselves who they want to spend time with, when and how without practitioners' intervention:

> '... people support each other on an informal basis ... through the general relationship building and social interaction opportunities of the service ... there are two people who have moved on in the last two months and to the pair of them now, they spend a lot of time socialising, , but 10 months ago it wasn't like that.... I don't think you could have set that up even with the best of plans.' (NHS, practitioner)

If users did express that they would benefit from support groups and there were not opportunities to access this kind of service 'in-house' because it was not part of the organisation's remit or they did not have the funds to expand this side of the service, then again it was seen as part of the practitioner's role to signpost users to relevant services, and there did not appear to be any obstacles to doing this.

Sharing case studies of success stories with other people who use services was seen as a valuable way of motivating others to see and really believe in the benefits of pursuing vocational goals:

> 'Using people who've gone through the system and received support and have managed, that's probably the best tool that we have in encouraging people'. (social services, practitioner)

> 'We can preach till we're blue in the face about the benefits of work but if it comes from somebody who's used the service and experienced that in a positive manner it's more appropriate, it's got more emphasis there.' (social services, practitioner)

Peer support was seen by practitioners as a powerful way to demonstrate that having mental health problems does not mean you cannot think about exploring

employment, training or education opportunities. It was also considered to be something that practitioners who had not experienced mental health problems or services could not give – empathy based on experience. The move towards employing staff or volunteers with mental health problems or a history of mental illness was another avenue many services were looking to expand on further, time, and resources permitting. Overall, the benefits of peer support were seen as a valuable contribution to training and vocational services.

Respect: 'Working together'

Interviewees were asked to explain how they built working relationships with people who use services and any barriers that might impede this process. In most cases respondents referred once more to the individual nature of service delivery and the importance of adopting one-on-one approaches.

Practitioners talked about working with people who use services as equals in open, respectful and honest ways, seeing this as a central tenet to any working relationship:

> '... the fact that you are person-centred means that you are starting up that relationship based on respect....' (NHS, manager)

Practitioners stressed both their formal training and the individual skills and abilities they used to work with people who use services in a sensitive and reflective manner. Working out how best to approach and work with people who use services that suited their needs was seen as requiring dedicated time, space and resources:

> 'One of the main problems is that funders want more people to come through the books but with a person-centred approach it's not all about numbers it's about quality. So there are some instances where it's going to take much longer to build that relationship ... to build trust.' (voluntary/not-for-profit, manager)

Many of the practitioners were aware of 'undoing' people who use services' negative association with mental health practitioners in order to build positive relationships:

> '... if you're saying to people we're working with you in an open way and we'll follow your lead ... the only way you can do it is with honesty and openness, otherwise you're part of a system which probably got them where they are in the first place and that's not going to do anybody any good, nobody will trust you.' (NHS, practitioner)

Overall, practitioners were aware that the responsibility for building positive working relationships based on respect, compassion, understanding and honesty lay with the ethos of the organisation and individual practitioners working within that ethos. If this did not happen then it was the responsibility of the practitioner to change, not the service user. Regular staff reviews and assessment of working practices were used to ensure that these standards were adhered to. While recognising that this was not perfect, regular forms of staff supervision was seen as one way of developing reflexive working practices.

Practice example 3: Black and minority ethnic employment service

A local employment service for black people aged 18+ with mental health is being run in the Sandwell Borough. Referrals are made via community mental health teams, disability employment advisers other employment projects or self-referral. The aim of the service is to support users' access to voluntary work, vocational training, to provide job-searching skills or support people in retaining employment despite mental health difficulties.

The aim is to support people who use services in a flexible way to achieve their goals. Through long-term engagement and intensive one-to-one support with users it is possible to identify and build on their strengths. This is also made possible once someone has gained experience through voluntary work or training and can strengthen their CV. Other services are also provided within the organisations that support people in other areas of their lives such as a counselling service, drop-in centre and outreach service. The services maintain regular contact in order to provide practical and emotional support, and liaise with their care coordinator. People who use services provide support to one another through them coming into contact through the job club, a forum where users can make decisions about the running of the organisation as a whole. There is a transitional process from joining the service and receiving intensive support and motivation (dependence) through to less support over time (independence).

Responsibility: 'Encouraging people who use services to take responsibility for their actions and progress'

There was a strong drive from interviewees to make it clear that as much as they were providing a vocational and training service, supporting people to move forward in their lives and reflect on their current circumstance, they were not forcing people into jobs or situations that they did not want. One practitioner surmised:

> '… it's about the ethos of enabling, rather than doing, supporting not doing for things for people.' (NHS, manager)

Openness and honesty were considered the best approaches to take when communicating with people who use services about their roles and responsibilities in the vocational process. It was considered essential to establish the organisation's expectations from the beginning to avoid any miscommunication or misunderstanding. The general consensus was that unless a service user owned their own vocational path it would not succeed:

> 'I'm really honest and open with them from the beginning. We're not here to do everything for you…. You have to make it work as well, but we're here to make it work.' (voluntary/not-for-profit sector, practitioner)

The aim, many practitioners stated, was to maintain a balance between supporting individuals but not to do things for people, and, more importantly, users not saying yes and agreeing to pathways to please practitioners.

Although time and perseverance were seen as key skills in developing relationships with users, many citing an 'it takes as long as it takes' approach, practitioners were alert to not encouraging over-dependence on a service or a person. A small number commented on the need to remain alert to the power imbalance in their relationship with users. For some this went further than encouraging users to own and take responsibility for their vocational process, but that it was about recognising the vulnerable position many users were placed in:

> 'We are in a very powerful position … the minute you are in a position when someone needs your support or advice, people are going to come and tell you things that are very personal about themselves … well, you could make or break someone….' (social services, practitioner)

Hope: 'Giving people the message that they can achieve their goals'

Giving people who use services the message that they could achieve their goals was seen as part of the attitude a person adopted when working with users and having a strong belief in each person's capabilities. One person stated:

> 'I'm very much a firm believer that mental health is episodic and when people are well, they're well and they can move mountains. When they're unwell they need a bit more support but that is a period that will pass.... It's all about having the confidence in the person, and hopefully that attitude will transfer to them.' (social services, practitioner)

Low expectations were identified as a serious concern to overcoming a lack of belief in the ability of individuals to achieve vocational and training goals. One person also commented on raising the organisational level of expectation among staff:

> 'I think we need to start raising our level of expectation – it's great that everybody's achieving and everything is positive but really that should be the expectation….' (NHS, manager)

Again, practitioners talked about the importance of reversing the negative messages people who used services had received which led them to have low expectations about their own abilities and, users' fears and anxieties that participating in employment or education would make their 'illness worse'.

Practice example 4: Social enterprise

A voluntary non-for profit, social enterprise in Manchester has a 'Workstep' contract, a type of supported employment programme, with a local council. This enables them to support people with mental health problems gain paid full-time and part-time work. The employment service is tailored to each individual's specific employment support requirements. The length, intensity and type of support can be decided by each service user. Staff will initially meet with people who use services to build a profile based on a person's skills and interests with the aim of enabling users to recognise their own strengths. Follow-up meetings can

then be arranged on a regular basis. Reviews and feedback on progress are built into to each meeting. Staff will support any aspect of a person's life that may be impacting on work, such as medical issues, housing or finances. If support cannot be provided 'in-house' users will be signposted to relevant services externally. People who use services are encouraged to contact the service during times of mental distress for additional support. Staff can provide on the job support and regular visits once a person first starts working. The aim is to gradually reduce support as users move on in their vocational process.

Social inclusion: 'Linking with mainstream services'

We asked practitioners how linking with mainstream services worked in practice and how they went about achieving partnership working, networking and linking in with the community. Although practitioners would have links that they had established over time, this side of the service appeared to be demand-led. For example, if the service user was interested in taking part in certain types of workshops or activities then the practitioner aimed to find the services that would meet those needs:

> 'I'd say it's being aware of each other's organisations' outcomes and working with that to get the best result for the individual.' (voluntary/not-for-profit sector, practitioner)

> 'We've got our key partners, around the college, volunteer bureau, a couple of the employment organisations locally, so we've got that. It might be a certain individual wants to achieve something, so you might have to go and find someone else who actually has that. There is a core partnership which is good, and peripheral ones that you dip in and out of, you build as you go along.' (NHS, practitioner)

Linking with mainstream services was particularly apparent when supporting people who use services to find employment or training:

> '... people get a job by talking to employers and engaging with employers, meeting the need of those who want a job and those who want to employ people in jobs.'

One of the major obstacles to accessing mainstream services was being dependent on what was available because of current funding opportunities and general employment opportunities in the area. For example:

> 'It depends on what's happening, sometimes people get a pot of money, so you might have more contact with them, because of that source of funding.' (voluntary/not-for-profit, manager)

> '... the jobs have to be there for it to work....' (NHS, practitioner)

> '... services get funded, run in the community, like learn direct and they get the plug pulled after a year, people start using a service and benefiting from it, then it's gone and I can't refer them anymore.' (voluntary/not-for-profit, practitioner)

Overall, there seemed to be an expectation that it was the individual practitioner and their ability to keep up to date and find out what was going in a local area that determined the extent to which links with the wider community were made.

4.6 Conclusion

The results of the practice survey revealed that those providing vocational and training interventions in community-based adult mental health services who participated in the practice survey applied many of the dimensions of the recovery model in their work. This was despite the majority of respondents not using the term 'recovery' or providing an overall model of practice to explain their work (see Section 4.4 and 4.5).

5 Key findings and conclusions

5.1 Introduction

This chapter considers all of the data in the knowledge review from the research review on outcome studies and on process evaluation studies and from the practice survey. The discussion is structured around the dimensions of recovery introduced in Section 1 (see Section 1.2.1) and used to structure the reporting of results of the process evaluation studies and of the practice survey.

The research studies to date have revealed many of the possible processes by which training and vocational services can adopt recovery-orientated practice. However, these examples of practice are not as detailed as the data provided in the practice survey undertaken for this knowledge review. The need for further process research is required to be able to identify the circumstances in which different aspects of recovery-orientated practices are or are not most successful and developing theoretical models to explain and predict this.

The results of the review of outcome studies was reported differently according to outcomes of self-esteem, social capital, engagement in daily living activities and quality of life. The results of the outcome studies were not very consistent, so little can be said about their relation to the dimensions of recovery although indications for how best to focus any future research effort can be made. Future studies need to have increased rigour and to build on precious research to allow a statistical meta-analysis of effect size so that the results of inconsistent studies can be combined to measure the overall statistical effect. Studies are also required to assess the impact of specific aspects of the different recovery dimensions identified by the process studies and the practice survey.

5.2 Key findings for each dimension of recovery

5.2.1 Person-centred and strengths-based: 'Tailoring services to individual aims, aspirations and strengths'

Process evaluations and the practice survey

The process evaluation studies reported that all intervention types used some form of person-centred strengths-based approach to service delivery in an attempt to work more effectively at supporting people who use services to achieve their vocational goals.

The practice survey identified many aspects of recovery-orientated processes related to the delivery of person-centred and strengths-based approaches.

Identifying strengths

Moving away from traditional models of mental health services that have been criticised for focusing on people's deficits and deficiencies, findings indicate that there are example of practitioners who focus on people's current skills, strengths and capabilities.

Encouraging self-confidence

In order to look beyond any difficulties a person might be facing at any point in their recovery process and to believe in the person's abilities and potential requires practitioners to communicate positive and encouraging attitudes.

Trust and empathy

A user–practitioner relationship underpinned by trust and empathy can facilitate working with people who use services within a strengths-based model of recovery. This can also give people the message that they are valued and in turn increase their own self-confidence. Some practitioners emphasised the importance of relationships over procedures such as form filling, but this can also obviously lead to dangers of lack of process, consistency and accountability in service provision.

Courses

In addition to one-on-one work with practitioners, people who use services can also be referred to confidence-building courses, go on skills training courses or gain work experience.

Timing of experience of work

Gaining quick experience through employment and training can give people a concrete example of their own abilities, skills and competencies. This allows both an assessment of strengths and difficulties in employment and provides people who use services with experience and confidence for further employment. Others argue that a slower move to employment allows more time for assessing strengths and potential difficulties in advance. Although the slower approach may help to avoid negative experiences from employment, one of the process studies[13] discussed the dangers of the lack of initiative to find employment may result in a passive approach and employment not being found.

Volunteering

This was valued by some practitioners for building confidence and work experience. Others did not consider it work and that it diverted attention and resources from the search for employment.

Specialist employment advice

Employment services were seen as a key resource in securing employment.

Models of working

Many respondents articulated recovery-type positions such as a focus on users' needs and working with people who use services, but only a few respondents indicated the explicit model or approach they used.

Outcome studies

The research findings were inconsistent on whether a recovery approach objectively improved self-esteem, but there was some evidence that people who used services believed that it did.

Research needs

In addition to the general research needs described in Section 5.1, process and outcome studies could look more specifically at how a strengths-based approach links to confident behaviour and to the self-concept of self-esteem. Currently most studies only study self-esteem and this is not investigated in relation to the recovery dimensions of strengths revealed by process research and the practice survey.

Practice messages

- Aiming to deliver services within a person-centred framework is a key factor in helping people who use services identify, find and continue with training and vocational goals.
- Delivering person-centred training and vocational services can be achieved by adopting strengths-based approaches that work with people who use services to identify what they think they are good at and what they want to do with their life.
- Delivering person-centred strengths-based approaches requires positive working relationships between users and practitioners.

5.2.2. Holistic services: 'Linking with other aspects of life'

Process evaluations and the practice survey

The process evaluation studies reported that working within a person-centred approach often meant addressing the wider aspects of person's life including identifying any barriers to employment. Practitioners play an important role in supporting people who use services to address and remove those barriers.

The practice survey provides further details regarding how these processes operate in more detail and revealed many aspects of a recovery approach linking with other aspects of life.

Non-vocational services

Some advocate dealing with non-vocational issues prior to employment issues. This links with timing of work experience under the strengths dimension.

Referral to or work with other services or in-house services or holistic services

Common approaches to working with people who use services on non-vocational issues were to signpost and refer (including support and advocacy) users to other, more appropriate services. In order to meet the non-vocational needs of users meant that professionals needed to link with and work with other organisations that could fill the gaps vocational and training services could not address. Other organisations operated a more mixed approach, whereby if needs could be met 'in house' they would signpost and refer. The aim of some organisations was to have a broader remit than looking at vocational and training needs to provide holistic services. There could sometimes be difficulties in relating to other services.

Arising from team working

One way of identifying what non-vocational support a person might need was by working with other professionals to discuss with the service user other aspects of their lives.

Outcome studies

All of the outcomes examined in the research review could be important in terms of how services relate to other aspects of the lives of people who use services, but these were not evaluated in the studies in the review.

Research needs

Process research and the practice survey have identified a number of aspects of the wider context of users' lives in relation to recovery-based services. Outcome research is required on the impact of different ways of organising such service provision.

Practice messages

- Working with people in training and vocational settings also means addressing the wider aspects of people's lives, particularly housing, medication, financial well-being and therapeutic needs.
- If the wider aspects of people's lives cannot be met by one service, adequate signposting and referral systems need to be set up to ensure people who use services know where and how to access them.
- Training and vocational practitioners often take on an advocacy role when working with the wider aspects of users' lives, ensuring that they receive services they are entitled to.

5.2.3 Flexible and non-linear services: 'Dealing with setbacks in mental health'

Process evaluations and the practice survey

The process evaluation studies reported that service coordination and communication between vocational and training practitioners and community

mental health teams is a key part of supporting people when they experience setbacks in their mental health.

The practice survey identified several issues related to the need to support people who use services when they experienced setbacks in their mental health. This raised the importance and challenge of organisational structures supporting practitioners to be able to work in flexible and non-linear ways.

Support

Findings from the survey indicate that practitioners actively engage with and support people who use services when they experience setbacks in their mental health.

Refer for help

If increasing the intensive one-to-one support already available was not sufficient, then practitioners would refer people who use services to community mental health teams or their care coordinator and may work closely with them.

Managing mental health symptoms

In some cases it was possible for practitioners to work with people who use services to help them understand why they had experienced a setback and support users to 'manage' mental health problems.

Joined-up services/continuity of care

Practitioners talked about the extent to which supporting people when they experienced a setback in their mental health was made easier when community mental health teams were 'integrated' with training and vocational services. When services were joined up there was less disruption to the continuity of care provided. If people who used services were discharged from secondary mental health services then linked up work could be more difficult. This was also linked to organisational issues of in house versus referring out to other services. These finding were supported by the process evaluations. Grove et al[58] and Gowdy et al[13] considered that providing in-house forms of therapeutic support was beneficial to the vocational process. Drake et al[9] advocated adding vocational specialists to community mental health teams to increase communication between both sets of professional to reduce the risk of disengagement of users from training and vocational services because of relapses in mental health.

Monitoring and flexible approaches to crises and changing needs

Practitioners were aware that supporting people who use services to re-enter employment, training or education was unlikely to be a linear process and this required monitoring. They were prepared to be flexible regarding how and when users accessed their services, with many operating an open-door policy. Interviewees talked of being prepared for relapses and identifying triggers and not seeing these as barriers to seeking employment.

Outcome studies

Setbacks are most clearly associated with the research outcome of engaging in daily living activities and reductions in mental health symptoms. Two studies in the research review reported supported education as being associated with better coping with stress from studying. Apart from this there were no studies directly examining this issue.

Research needs

The process research to date has identified a number of issues that outcome research could evaluate in terms of dealing with setbacks and the type and organisation of services to respond.

Practice messages

- Practitioners who are seen as part of someone's care team appear to be able to provide more specific employment support to people who use services when they experienced setbacks in their mental health than those who were less involved.
- Care planning need to emphasise continuity of care as people who use services move through the mental health system.
- Communication between professionals and an understanding of the different roles different professionals have in a service user's life is the key to providing consistent and complimentary support.

5.2.4 Peer support: 'People who use services supporting each other'

Process evaluations and the practice survey

The process evaluation studies reported that learning from the experience of their peers is another way in which people who use services can be supported and believe in their abilities to achieve their vocational goals.

The practice survey identified several issues related to peer support.

Peer engagement processes or opportunities

The nature of many training and vocational services is to provide one-on-one support only that can mitigate against mutual peer support. For some services, there were opportunities for people who use services to come into contact with each other and receive support under natural circumstances. This finding was supported by Henry and Lucca[17] that found participating in group service activities provided ways for users to give and receive support from each other. In some cases there were structured systems to enable contact and support. In others, if peer support was a recognised need, then again practitioners would look to signpost and refer users as appropriate. In others, such approaches were considered controlling and users made relationships if they wished to.

Peers as models

Services provided examples of where peer support was being approached through role modelling and case studies of former service user experiences of gaining employment. This was indirect peer support where peers did not necessarily have to meet but just learn what others had achieved. Employing people who use services as workers could provide employment and provide role models to other users.

Outcome studies

This aspect of service delivery is most closely associated with social capital and engagement outcomes but this was not an explicit focus of studies in the research review.

Research needs

The seeming lack of enthusiasm for peer support does not mean that it is not an important component of service provision. Compared to other areas this is under-researched in terms of process which is needed to clarify what outcome studies might best be undertaken.

Practice messages

- Training and vocational services need to balance their provision of person-centred one-on-one approaches with opportunities for people who use services to benefit from others who have been through similar experiences.
- Sharing case studies of success stories with other users was seen as a valuable way of motivating others to see and really believe in the benefits of pursuing vocational goals.
- Providing opportunities for users to also be part of delivering services is another way to promote positive peer-to-peer messages.

5.2.5 Respect: 'Working together'

Process evaluations and the practice survey

The process evaluation studies reported that the service user–practitioner relationship underpins the construction of hope-inspiring relationships and facilitates the delivery of person-centred, strengths-based models of working.

The practice survey identified many dimensions to professionals and users working together.

Respectful, professional, explicitly accountable service

Staff are responsible for ensuring that they work with people who use services within an ethos of respect and equality. Organisational systems and procedures also need to support individual practitioners to be able to work with users in ways that can facilitate individual recovery processes and any training and vocational aspirations.

Valuing the service user

Services appeared to be more geared to providing opportunities to value the input of people who use services, whereby they are the 'experts' of their own recovery processes, and to be sensitive to service user needs.

Encourage and give hope

The underlying message is that user–practitioners' relationships that inspire hope and offer encouragement are essential to the delivery of training and vocational services that aim to benefit the user.

Joint goal setting and ownership of plans

Joint goal setting was one way that practitioners formally encouraged people who use services to take ownership of their vocational progress.

User responsibility

The approach taken with the majority of services was to emphasise people who use services taking responsibility for any decisions they made towards vocational and training goals.

Working with, not doing to, people who use services

Relationships based on working together. This was made easier by the fact that people who used services could choose whether to explore vocational and training pathways. Services emphasised working with and supporting users to achieve what they wanted to do, as defined by them.

Undoing negative user perceptions from prior experiences of services

People who use services come with a history including prior non-person-centred services. This may have left them with low expectations of what they could achieve and support may be required to enable them to re-build their confidence and re-take control of their own lives.

Resources and organisational ethos

Working in this way with people who use services requires resources and the organisational ethos of being open to change. This may involve providing training and opportunities for reflection through support and supervision to underpin working in a recovery-focused way.

Outcome studies

Working together could have an impact on all outcomes but was not a specific focus of the studies in the research review.

Research needs

Working together is a central component of services based on a recovery model, so research is needed on each aspect of this identified by the process studies and practice survey.

Practice messages

- Working with people who use services as equals, in open, respectful and honest ways, and seeing this as a central tenet to any working relationship, is a fundamental recovery approach.
- Organisational systems and procedures need to support individual practitioners to be able to work with users in ways that can facilitate an individual recovery processes and any training and vocational aspirations.
- Regular forms of staff supervision is one way of developing reflexive working practices and ensuring recovery-orientated approaches are being maintained across the service.

5.2.6 Responsibility: 'Encouraging people who use services to take responsibility for their actions and progress'

Process evaluations and the practice survey

The process evaluation studies did not provide much information about how practitioners encourage people to take responsibility for their actions and progress. One study briefly reported working with people who use services at their own pace.

The practice survey identified several dimensions of users taking responsibility.

People who use services taking responsibility

The approach taken with the majority of services was to emphasise that users' took responsibility for any decisions they made towards vocational and training goals. This also avoided dependence.

Joint goal setting and ownership of plans

Joint goal setting was one way practitioners formally encouraged people who use services to take ownership of their vocational progress.

Power and professional honesty

Practitioners outlined that working 'with' people who use services required being honest, providing encouragement and not pressure to 'succeed' or 'recover'. It also included remaining alert to the power imbalance between practitioners and users who might feel they needed to act in ways that pleased professionals rather than addressing their own concerns, needs, wants and aspirations. The study by SESAMI[78] also pointed to the importance of not pressuring users into vocational pathways that

were not of their own choosing because this could block a person's ability to take responsibility for their actions and make decisions based on their own initiative.

Outcome studies

This dimension of recovery could be associated with any of the four study outcomes yet was not the focus of any of the studies.

Research needs

All of the identified aspects of this dimension are open to new research.

Practice messages

- It is vital that a person who uses services owns their vocational path otherwise it will not succeed.
- It is the responsibility of practitioners to ensure they work in ways that foster independence not dependence within the user–practitioner relationship.
- The power imbalance between users and practitioners needs to be acknowledged and addressed if services can claim they are working within a recovery model

5.2.7 Hope: 'Giving people the message that they can achieve their goals'

Process evaluations and the practice survey

The process evaluation studies reported that practitioners' attitudes towards people who use services were their greatest asset to conveying a message of hope regarding a person's chances of achieving their vocational goals.

The practice survey identified how practitioners could give people the message that users could achieve their goals.

This was made easier by the fact that users could choose whether to explore vocational and training pathways. Services emphasised working with and supporting users to achieve what they wanted to do, as defined by them.

Goal setting with small steps

One way practitioners were able to convey to people that they could achieve their goals was to work with users to set tasks that were manageable for them. The study by SESAMI[78] talked about working with users to set manageable and achievable goals that were owned by the user.

Acknowledging success

Practitioners also talked about the importance of acknowledging success in terms used by the service user and building on any progress made, regardless of their size or impact.

Accepting setbacks

There was an awareness that mental health problems could be episodic and could set back progress.

Believing in the service user

Again, a significant part of the practitioner's role is to believe in the service user and their progress, regardless of whether things were going 'well' or not. Practitioners talked about building confidence in people who use services through praise and positive reinforcement and reversing negative messages and raising expectations. Gowdy et al[13] reported that services with the highest employment outcomes gave this message and acted in a way that employment was achievable.

'Can do' attitude

Practitioners also felt that having a 'can do' attitude was a beneficial approach to take with people who use services who might lack hope and confidence in their recovery process.

Outcome studies

This was not a specific focus of most of the outcome research studies.

Research needs

More specific studies of how belief in employment results increased employment rates.

Practice messages

- Practitioners working in training and vocational services have an opportunity to work with people in positive and empowering ways that can undo negative messages clients may have previously received from the mental health system that lead them to have low expectations about their own abilities.
- Giving people the message that they can achieve their goals is a professional skill that includes breaking down goals into manageable steps, working with users' disappointments and hurdles, believing in people and having a 'can do' approach to working.
- Organisations' systems and structures need to support individual practitioners to raise their expectations regarding what people are capable of and adopt risk taking, not risk adverse models of ways of working to be compatible with a recovery approach.

5.2.8 Social inclusion: 'Linking with mainstream services'

Process evaluations and the practice survey

The process evaluation studies reported that they linked with mainstream services when considering the wider aspects of people's lives but they did not explore the processes by which they made this happen in any explicit detail.

The practice survey identified the following aspects of linking with mainstream services.

Partnerships and networks and links between organisations, the community and personal links

Partnership working, networking and maintaining links between organisations was one of the main ways services linked with mainstream services and activities. Many links were also made through the community and through personal and named contacts. Sometimes there were frequently used core partners and a wider range of more peripheral partners.

Maintaining links

Links remained active through referral procedures and by contacting other organisations on behalf of users as a person-led service of referral.

Outcome studies

This was not a specific focus of most of the research studies although is related to the extent that services are holistic or mental health-specific.

Research needs

The research needs relate to the organisation of services and users' own links with their communities and local services.

Practice messages

- Organisations mainstream services through 'partnership working' or 'networking' in order to be more socially inclusive.
- Resources need to invest in services which can support people to access mainstream services and take advantage of any opportunities that exist in their local communities.

5.2.9 Obstacles and barriers

Process evaluations and the practice survey

The process evaluation studies reported that the benefits system, transportation, the beliefs and skills of people who use services and family difficulties were the major barriers to employment.

The practice survey may give the impression that awareness of recovery approaches to mental health services is high and is unproblematic. However, the survey also identified a number of barriers to recovery approaches being implemented successfully.

Resources

Participants cited the insecurity of funding and lack of continuity of services as a major obstacle to delivering training and vocational services.

Stigma

The social stigma that surrounds mental health was seen as a considerable barrier for people thinking about vocational and training goals. This included lack of understanding by staff from community mental health teams who may consider that training or work may negatively impact on people's mental health.

Public and employers

There were numerous misconceptions made by staff, employers and the general public about the impact of mental health in people's life. This can lead to employers being reluctant to take on staff who have mental health problems.

Medical model rather than recovery model in staff

The pre-dominance of a medical model rather than a recovery model has led to a lack of understanding regarding the benefits rather than the disadvantages of engaging in work and other forms of meaningful occupation.

Organisational issues

There have been difficulties in the way people try to work together to provide continuity of care and structural changes in local government that increase staff turnover and decrease communication and impact on the way the NHS and social services work in practice. Changes in availability of services also meant that there was a need to keep up to date with local knowledge on service availability.

User confidence, motivation and trust

People who use services overcoming their own personal barriers, such as lack of confidence, motivation and mistrust of services were also cited.

User' inability to work due to medication/sick leave

Users' inability to work because of sick leave was also seen as a barrier to re-entering employment.

Benefits system

The complexity of the benefits system and the lack of information regarding what people are entitled to and when, remains a real barrier for people considering re-entering the work force or going into full-time education. The process evaluations also showed that addressing the issues of benefits was a valued part of their role.

Transportation

Not being able to access services because of lack of transportation and the isolation from living in rural areas.

Job opportunities and access in the area

The possibility of employment was constrained by job opportunities. The employment service was a central aspect of service provision.

Outcome studies

Barriers to the use of the recovery model were not a feature of studies except for the process study by Gowdy et al[13] which identified features of services with lower outcome rates of employment. These features included a belief that employment was a possibility and being strategic about how this could be achieved.

Research needs

There is a richness of data on positive dimensions of recovery models of service but little data on what distinguishes successful or unsuccessful services and barriers to success. In addition, there may be some adverse effects of the recovery model. For example, adverse effects related to the responsibility put on people who use services to determine what is success for them.

Practice messages

Supporting people to overcome barriers to engaging in employment, education or other meaningful activity is a key part to providing recovery-orientated training and vocational services.

5.3 Summary of key findings

This knowledge review contains two main components of a research review and a practice survey.

5.3.1 Summary of findings from the research review

The research review includes a review of the research evidence on outcomes of recovery approaches to vocational interventions on non-vocational outcomes. Twenty-one outcome evaluations met the inclusion criteria and were judged to be methodologically sound; they were published between 1991 and 2006 and evaluated

a range of community-based training and vocational interventions measuring vocational and non-vocational outcomes.

The majority were conducted in the US (*n*=16), three in the UK and one each in Canada and Europe. There was little evidence to suggest that different types of training and vocational interventions lead to differences in non-vocational outcomes. The research evidence was not conclusive with predominantly inconsistent findings of the impact of these interventions on self-esteem, social capital, engagement in daily living activities and quality of life (see Section 3.3.7). Although many studies reported an effect of an intervention there were many other studies reporting no evidence of effect. The only areas where there seemed to be consistent effects was voluntary work and supported education programmes impacting on participants' self-reports of improved self-esteem, supported education helping participants' ability to cope with the stress of studying, and most studies on voluntary work and education showing an improvement in quality of life.

It seems likely that non-vocational domains of outcome are only weakly related to vocational engagement and that programme effects are specific to the content and delivery of the programme. Another possibility is that people who use services need more time in employment, training or education before vocational gains can be generalised to other non-vocational domains.

The research review also included a review of the research evidence on the processes by which recovery interventions impact on vocational and non-vocational interventions. Six process evaluations met the inclusion criteria and were judged to be methodologically sound; they were published between 1992 and 2006. Four were conducted in the US (*n*=4) and two in the UK. The studies identified a wide range of components of recovery approaches to vocational interventions. These studies were rich in suggesting components of recovery but provided little detail of the mechanisms by which these are achieved or what features would differentiate successful and unsuccessful services and barriers to effective services. A greater richness of detail was provided by the practice survey although this also did not provide great differentiation between different recovery strategies.

5.3.2 Summary of findings from the practice survey

The practice survey found that there are different ways in which training and vocational services can approach working with people who use services to support them in accessing employment, education or training using person-centred approaches to facilitate recovery. These include traditional train-and-place approaches that emphasise rapid job searches and obtaining competitive paid employment. Other approaches include longer preparatory stages that can enable more time for users to build confidence and gain work experience before taking on full-time employment.

Practitioners provided examples that indicated that strengths-based approaches are both an attitude and a set of practices. Practitioners aimed and believed in working with people to build on their strengths, competencies, accomplishment, goals and

motivation. The service user–practitioner relationship was the primary mechanism in which strengths-based approaches operated.

Practitioners were willing and able to support people with wider aspects of their life and when they experienced setbacks in their mental health, but they often came up against issues such as: a lack of service coordination, accountability and problems with communicating with other relevant mental health practitioners.

There are varying ways in which training and vocational services attempt to provide opportunities for people who use services to support each other, but it featured more as an 'add-on' to services than being integral to service delivery.

There appeared to be a tension between developing relationships with people who use services, taking the time to develop trusting relationships, having open-door policies and the pressure regarding funders to have hard outcomes such as the number of people working and 'in a job'.

Findings also indicated that supporting people to understand, acknowledge and take responsibility for the trajectory of their vocational process placed practitioners in positions of power that were open to being abused.

In many circumstances training and vocational services need to support users in overcoming barriers to employment. The most commonly cited issue was supporting people to navigate the complex and sometimes confusing route between receiving benefits and entering into employment or full-time education.

5.4 Discussion

The overall aim of this knowledge review has been to synthesise the impact and process of recovery-orientated training and vocational interventions on non-vocational outcomes and to survey current practice to explore the extent to which training and vocational interventions in the UK may be adopting recovery-orientated approaches.

From looking at the studies in the research review it is difficult to make associations between the delivery of an intervention and specific vocational and non-vocational outcomes because of the complexity of delivering interventions in community-based mental health services. Some of the training and vocational interventions included in the research review evaluated change from baseline while others did an inter-programme comparison. Due to lack of randomisation at baseline, the outcome of studies that only consider inter-comparisons between groups could be flawed, hence emphasising the need for random allocation to groups. Also, none of the groups included in the studies have been compared to the non-mental health population and therefore it is hard to tell if the improvements that are reported are significant enough. A study by Torrey et al[85] explains how non-vocational outcomes may not be related to vocational outcomes but may be interrelated to each other and that changes in non-vocational outcomes such as self-esteem may take time to show. Based on the studies suggestions, the follow-up period of studies should be recorded. It also identifies the need for long-term follow-up or longitudinal studies in this field.

The majority of studies included in the research review have quantified non-vocational outcomes using objective measures based on clinical and social recovery criteria. This often ignores the subjective experience of people's everyday lives and individual interpretations of what is significant to them. There is an absence of service user-defined non-vocational outcomes in the research evidence base. There is a rich opportunity for evaluations of training and vocational interventions to explore the impact of different forms of 'meaningful activity' on levels of hope, sense of autonomy, self-esteem, community participation and how mental health symptoms are experienced and perceived, rather than measured.

Although the findings from the practice survey provide examples of emerging recovery-orientated practice, there continues to be an important distinction, between training and vocational services which are adopting recovery-orientated approaches and services which are taking a traditional rehabilitation approach. The distinction lies not just in the difference between 'doing with' (recovery) and 'doing to' (rehabilitation) approaches, but also with who is setting the goals. There is a tension between providing focused services that emphasise employment or education goals and people who use services who may want to receive support towards exploring other forms of 'meaningful activity'. Many may consider the stress of work or education to be damaging to their well-being or because 'meaningful activity' may actually mean something different to them. We have looked at recovery within a vocational paradigm; however, for many people their personal recovery approach may not equate with employment or education nor may it be a first step towards re-engaging in meaningful occupation.[91] A study by the Brighton & Hove Day Services Service Review User Committee,[45] which looks at user views, supports this argument, stating that 'even though employment and higher education will be a stated goal for many service users, it must be recognised that not everyone will be able to achieve this objective in the short and perhaps even medium term' (p 18).[45] Any assumptions made that employment and/or education is the route or an intrinsic part of anyone's recovery process runs counter to recovery values of individualised need and self-determination.

5.5 Recommendations for policy and practice

- To deliver hybrid approaches that can support people at different points in their recovery process, as not everyone can be ready to enter competitive paid employment but may still want support to explore avenues towards obtaining meaningful occupation.
- To deliver integrated training and vocational services, such as the approach taken by the IPS model, whereby vocational specialists join existing community-based mental health teams.
- To continue building peer support into services to enable people who use services to learn and benefit from other people's experiences and insights into their own recovery processes.
- To have secure forms of funding for training and vocational services that acknowledge and validate the importance of the work they do. To provide additional funds for more services to have open-door policies, whereby users know they have access to services and are not considered closed and 'recovered' simply because they re-entered the workforce.

- That services continue to have a dialogue concerning and addressing issues of the power imbalance between people who use services and practitioners and the implications this has for recovery processes.
- To provide accurate advice on and support with the welfare benefit system. This needs to be an essential part of any service that aims to support people to access work, education or other forms of meaningful occupation.

5.6 Recommendations for further research

- To explore the ways in which racism, sexism, ageism and other oppressive factors can affect the recovery process, and how training and vocational services and models of recovery are addressing these issues.
- To conduct user-led research which looks at whether training and vocational services allow people to determine what meaningful occupation means to them, and what they really want out of life and of the extent to which services have and can support people to do this.
- To conduct user-led research which explores the role of training and vocational services in influencing personal definitions of what counts as a recovery-based outcome.
- To conduct user-led research that explores both practitioners, and users' perspectives and experiences of recovery-orientated approaches in the delivery of training and vocational services.
- To conduct randomised controlled trials of the effectiveness of training and vocational services on non-vocational outcomes in the UK that builds on and tests the research evidence identified in the research review on outcomes.
- To undertake process evaluation research that develops models of recovery-orientated service delivery to differentiate the use of different combinations of service, user and contextual characteristics.
- To explore the impact of vocational services working with employers and potential employers, in order to both support individuals, and to promote further opportunities for the employment of people with mental health problems.

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Index

Supporting people in accessing meaningful work: Recovery approaches in community-based adult mental health services

The current social care transformation policy has at its heart the personalisation of services so that people can choose the type of support that is more suited to their individual needs and preferences. This knowledge review focuses on an approach to delivering mental health services that is vital to achieving personalised support for those accessing opportunities for employment, education and meaningful occupation.

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