

Growing the availability of evidence based supported employment

The majority of people with mental health challenges want to have a job (Rinaldi and Hill, 2000; Secker *et al.*, 2001) yet, among people using secondary mental health services, only 8 per cent are in employment (see IPS Grow, 2018). It does not have to be this way. We know that there are effective ways of supporting people with more serious mental health challenges to get and keep real jobs in open employment. Developed in the 1990s in the USA (Becker and Drake, 1993; Drake and Becker, 1996), at least 16 randomised controlled trials in different countries have demonstrated that Individual Placement and Support (IPS) evidence based supported employment is effective in enabling between 40 and 60 per cent of people with serious mental health challenges to gain and sustain employment (see Bond *et al.*, 2008). As a result the 2015 NICE quality standards for psychosis and schizophrenia[1] clearly indicate that this evidence based supported employment support should be provided for everyone who wishes to find or return to work. There is also increasing evidence that IPS is equally effective for people experiencing what have been described as “common” mental health challenges like anxiety and depression (Te Pou, 2014; Reme *et al.*, 2018).

Despite the strong evidence base and NICE guidance the reality is that most people who wish to work do not have access to the support they need to do so. Although the first IPS service in the UK was established in 1999/2000 such services are available to very few people. The 2018 National Service User Survey in England (CQC, 2018) showed that only 23 per cent said they had definitely received support to find or keep work – a significant fall from 27 per cent in the previous year. At the same time, 47 per cent said they would have liked help but did not get it – a rise from 43 per cent in 2017.

But things are changing.

The Five Year Forward View Implementation Plan (NHS England, 2016) requires a doubling of access to IPS from 10,000 people per year in 2017 to 20,000 in 2021 and additional (time limited) funding has been provided to facilitate this. The NHS long term plan (2019) makes it clear that this increase must continue:

Through increasing access to IPS, the NHS will support an additional 35,000 people with severe mental illnesses where this is a personal goal to find and retain employment by 2023/24, a total of 55,000 people per year. This investment will support people to get back into or gain access to employment. It will improve outcomes and recovery for people, meaning they spend less time in hospital and live healthier, happier lives. By 2028/29, we aim to extend this to 50% of the eligible population to benefit up to 115,000 people. (NHS England, 2019, p. 117)

It should be noted that this is not about forcing people into work with threats of withdrawal of welfare benefits but ensuring that those whose “personal goal is to find and retain employment” have access to the evidence based support they need to do so.

Across England many IPS services are being established all of which are based on 8 core, evidence based, principles[2]:

1. It aims to get people into open competitive employment “real jobs”.
2. It is open to all those who want to work [...] with no exclusions based on diagnosis, health condition or benefits claim.

3. It tries to find jobs consistent with people's preferences.
4. It works quickly [...] job search starts within four weeks, even if a client has been off work for years.
5. It brings employment specialists into clinical teams [...] so that employment becomes a core part of mental health treatment and recovery.
6. Employment specialists develop relationships with employers based on a person's work preferences [...] not based on who happens to have jobs going.
7. It provides ongoing, individualised support for the person and their employer [...] helping people to keep their jobs at difficult times.
8. Benefits counselling is included [...] so no one is made worse off by participating.

Some of the developing IPS services are provided by health services, others are commissioned from voluntary and a few private sector providers working within mental health teams. In some areas, existing IPS services are being expanded, in others, completely new services are being established, and on occasions, organisations who have hitherto provided other types of non-evidence based vocational support are converting to an IPS model.

In order to support providers and commissioners of these emerging services, NHS England and DWP has funded "IPS Grow"[3]. A national lead and seven regional leads[4] – all experts in IPS and establishing IPS Services – can provide implementation support (including communities of practice and networking events) workforce development (including workshops, training and e-learning opportunities) data tools and fidelity reviews. A website provides a range free materials, information and guidance for providers, commissioners, people who are wanting assistance to gain employment and people wanting to work in IPS services.

This support for implementation is important. The rapid expansion in process is extremely positive, and indeed overdue given that it is 20 years since the effectiveness of IPS has been demonstrated in randomised controlled trials. However, any expansion of this magnitude is fraught with problems. Already we are seeing problems with finding, training and developing the workforce of skilled Employment Specialists who provide employment support within IPS. If not more important is the challenge of finding team leaders with experience and expertise in IPS to lead the many emerging teams and supervise the Employment Specialist workforce.

There is also a danger that in efforts to increase the quantity of IPS provision, quality may be compromised. Fidelity scales and review methodologies[5] have been developed for IPS and these are important. Research shows that effectiveness in relation to employment outcomes, and cost effectiveness, are strongly related to fidelity (Bond, 2004; Grieg *et al.*, 2014; Lockett *et al.*, 2016). It is imperative that services adhere to all eight of the underpinning principles of IPS and it is not uncommon for a service to say they "mostly" do IPS and miss out one or other of the key principles on which it is founded. It appears that services sometimes struggle with "employer engagement" – developing relationships with employers – and integrating employment support and clinical treatment – ensuring that Employment Specialists are core members of the team. Without these, the effectiveness of IPS is reduced and employment outcomes compromised. The development of effective mechanisms for reviewing and improving fidelity of IPS service provision is critical.

The current expansion of the availability of IPS focusses on the number of people who can access IPS services. This is important, but it risks focussing IPS attention on how many people use the service rather than the number of people who gain employment. For example, there may be a risk of "cherry picking" (selectively directing resources towards those who are deemed more "employable" in contravention of the second principle of IPS outlined above) or that caseloads will creep up and intensity/duration of support reduced in order to achieve the necessary service usage numbers. The essence of IPS is a focus on enabling people to access open employment and this must remain the core focus of IPS services and the way in which their success is evaluated. Many mature services have found it useful to set targets for individual workers. In their initial discussions, the IPS Grow team have suggested that in a mature IPS service each full time Employment Specialist might be expected to work with a minimum of 45 people per year and

achieve a minimum of 24 employment outcomes. However, in a mature service, the caseload of an Employment Specialist will be balanced and comprise some people who require a lot of support to gain employment and others who have gained work and require a lower level of support to maintain their employment. In a new service, all those supported by the Employment Specialist will be at the often more intensive job searching stage of their journey and it takes time to provide information and develop the relationships necessary to provide an effective, integrated service. Therefore in the first year of the operation of the service, it may be more realistic to expect an Employment Specialist to work with a minimum of 35 clients and achieve a minimum of 17 employment outcomes.

However, there may also be two more fundamental issues to be addressed.

First, IPS was developed within secondary, specialist, mental health services and it is assumed that people will remain in those services for long periods of time and this receive ongoing employment support from the Employment Specialists within those teams. However, models of mental health support are changing. It is increasingly assumed that people with more serious, ongoing, mental health challenges will leave specialist mental health services when their mental health problems have stabilised and receive ongoing clinical care within primary care services (returning to secondary services only if their mental health problems deteriorate). However, while they may no longer need specialist mental health clinical treatment, people often continue to need employment support. It is not uncommon for an Employment Specialist to begin supporting someone to get and keep a job when they are in secondary mental health services but have to stop working with them when their treatment is transferred back to primary care.

One of the core principles of IPS is that ongoing support can be provided to both the individual and their employer for as long as is necessary. Some people will need continuous support, for others this may not be necessary, but as mental health conditions often fluctuate, it is important that a person can quickly and easily access support if they have problems. If we are to develop high quality IPS services it is critical that they span the primary/secondary care divide and provide the ongoing access to employment support that people may need if there are to sustain and prosper in employment.

Second, IPS services were initially developed to help people who were unemployed to first gain, and then sustain their employment: they have not been directed towards enabling people towards “job retention” – enabling people to keep their employment when they develop mental health problems and come into mental health services. In the UK, a substantial proportion of people are in employment (often on “sick leave”) when they first develop mental health problems and come to primary or secondary care services. Helping people to retain and prosper in employment after getting a job has always been a core part of IPS, but it is important also to help those who are in work to retain their existing employment, or retain their place in the labour market by moving to another job if this is more appropriate to their needs and wishes. It is absurd for an Employment Specialist in a mental health team to say that they cannot provide employment support until the person has lost their job! It is important that the roll out of IPS includes the possibility of helping those who come into secondary mental health services who already have a job to retain their employment. Successful UK IPS services have shown themselves to be as effective in helping people to retain and return to existing employment as they are in helping those who are unemployed to gain (Rinaldi *et al.*, 2010).

Finally, perhaps the most important risk to the expansion of access to IPS services is that, hitherto, the new monies for developing services provided within the Five Year Forward View are time limited. Those who have received funding have made undertakings to continue to fund the services after the additional monies finish [...] but with all the pressures on resources within mental health will these promises be fulfilled? It seems to us that there is a significant risk that, when the short term additional funding ceases IPS services will be cut. The real challenge will be to maintain the investment over the longer term and ensure that IPS becomes a core part of mental health services. We will only know that we have succeeded when an Employment Specialist is accepted as an integral part of a clinical mental health team (whether in primary or secondary care) – as integral and indispensable member of the team as the occupational therapist, psychologist, pharmacist, nurse or doctor.

Notes

1. www.nice.org.uk/guidance/qs80/chapter/Quality-statement-5-Supported-employment-programmes
2. <http://ipsgrow.org.uk/uploads/pdf/1.1-Investing-in-IPS-03.pdf>
3. IPS Grow website: <http://ipsgrow.org.uk/>
4. Regional leads <http://ipsgrow.org.uk/uploads/pdf/Team-Bios-2019.pdf>
5. www.centreformentalhealth.org.uk/ips-fidelity-scale

References

- Becker, D.R. and Drake, R.E. (1993), *A Working Life: The Individual Placement and Support (IPS) Program*, Dartmouth Psychiatric Research Center, Concord, NH.
- Becker, D.R. and Drake, R.E. (1996), "The individual placement and support model of supported employment", *Psychiatric Services*, Vol. 47 No. 5, pp. 473-5.
- Bond, G.R. (2004), "Supported employment: evidence for an evidence based practice", *Psychiatric Rehabilitation Journal*, Vol. 27 No. 4, pp. 345-59.
- CQC (2018), *2018 Community Mental Health Survey Statistical Release*, Care Quality Commission, London.
- Grieg, R., Chapman, P., Eley, A., Watts, R., Love, B. and Bourlet, G. (2014), *The Cost Effectiveness of Employment Support for People with Disabilities. Final Detailed Research Report*, National Development Team for Inclusion, Bath.
- IPS Grow (2018), *Why invest in Individual Placement and Support (IPS)*, Social Finance, London.
- Lockett, H., Waghorn, G., Kydd, R. and Chant, D. (2016), "Predictive validity of evidence-based practices in supported employment: a systematic review and meta-analysis", *Mental Health Review Journal*, Vol. 21 No. 4, pp. 261-81.
- NHS England (2016), *Implementing the Five Year Forward View for Mental Health*, NHS England, London.
- NHS England (2019), *The NHS Long Term Plan*, NHS England, London, available at: www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
- Rinaldi, M. and Hill, R. (2000), *Insufficient Concern: The Experiences, Attitudes and Perceptions of Disabled People and Employers towards Open Employment in one London Borough*, Merton MIND, London.
- Rinaldi, M., Miller, L. and Perkins, R. (2010), "Implementing the individual placement and support (IPS) approach for people with mental health conditions in England", *International Review of Psychiatry*, Vol. 22 No. 2, pp. 163-72.
- Secker, J., Grove, B. and Seebohm, P. (2001), "Challenging barriers to employment, training and education for mental health clients: the client's perspective", *Journal of Mental Health*, Vol. 10 No. 4, pp. 395-404.