

# Commissioning guidance

## Mental health and employment services

This document is intended as a resource for commissioners to use in the commissioning of mental health and employment services in their areas. It should be read in the context of relevant legislation, local and national procurement regulations, and other commissioning requirements.

This forms part of a suite of guidance documents, tools and templates developed by IPS Grow, a programme commissioned by NHS England and NHS Improvement to support the growth of IPS. IPS Grow is led by Social Finance in partnership with a consortium of IPS experts, including the Centre for Mental Health.

Further information can be found at [www.ipsgrow.org.uk](http://www.ipsgrow.org.uk)

# Guidance for the provision of employment support for people with mental health problems

## Introduction

### Context

1. This guidance is aimed primarily at NHS Clinical Commissioning Groups and Local Authority commissioners. It should be of use to mental health service providers, third sector and private sector organisations.
2. This document is intended to provide a high level framework for mental health and employment services, based on the evidence available and accumulated experience from practitioners. In line with the NHS Long Term Plan, the focus is on evidence based supported employment, known as Individual Placement and Support (IPS). However, it also aims to set IPS services in their wider context.
3. For further detail on commissioning IPS services specifically, please see the following documents, all available at [www.ipsgrow.org.uk](http://www.ipsgrow.org.uk):
  - a. Investing in IPS
  - b. Briefing note on the commissioning and procurement of IPS services
  - c. Model IPS service specification
  - d. Outcomes target calculator
  - e. Financial model template
  - f. Model IPS procurement method statement

### Scope

4. This guidance covers the provision of services to support people with mental health problems into paid, competitive work.
5. This includes the link between employment services and both primary and secondary mental health services.
6. It also includes how local employment support fits into the wider national context of employment support services for people with other health conditions and disabilities and those without a health condition or disability.
7. This document does not focus on:
  - a. Encouraging employers to improve (or avoid negatively affecting) the mental health of their staff;
  - b. Engaging employers, including public sector employers, to become more accommodating of people with mental health problems in their recruitment or management practices;
  - c. The link between mental health and employment strategies and wider health and wellbeing or local economic development strategies.

## The case for supporting people with mental health problems into paid work

8. Good work is good for people's wellbeing. Unemployment is damaging to people's wellbeing and the wellbeing of those around them. Unlike other negative life events, individual wellbeing does not adapt to unemployment. Wellbeing is permanently reduced while an individual is unemployed.<sup>1</sup>
9. Worklessness is known to have a detrimental effect upon health.<sup>2</sup> It has been associated with loss of physical and mental fitness, obesity<sup>3</sup>, low mood<sup>4</sup> and to pose a health risk greater than heart disease<sup>5</sup> and is associated with an increased risk of death particularly from suicide in unemployed young men<sup>6</sup>.
10. Finding and keeping a job brings many benefits for people with mental health problems<sup>7</sup>, including: financial independence<sup>8</sup>; improved self-esteem, greater well-being, greater social contact and independence<sup>9</sup>, and reduced use of community mental health services<sup>10</sup>.
11. People with mental health problems are significantly less likely to be employed than other groups. Around 44% of people with a mental health condition are in work. This is lower than the employment rate for all disabled people (51%), which in turn is far below the employment rate for people without health conditions or disabilities (82%).<sup>11</sup> For people with severe mental illness, the employment rate is even lower at just 8%.<sup>12</sup>
12. People with mental health problems have more than double the risk of losing their jobs than people without mental health problems.<sup>13</sup>
13. There are around 1.1 million out-of-work people with a mental health issue who are of working age in the UK. Half of those who claim Employment and Support Allowance (ESA), 961 thousand people, report their mental health issue as their primary health condition.<sup>14</sup> Whilst these raw numbers have changed over time the disparity has remained.
14. The majority of people with severe mental illness consistently say they want to work<sup>15</sup>. People with mental health problems frequently put work at the top of their

1 What Works Wellbeing (March 2017), based on systematic review of evidence

2 Waddell, G. and Aylward, M., 2005. The scientific and conceptual basis of incapacity benefits. TSO.

3 Viner, R.M. and Cole, T.J., 2005. Adult socioeconomic, educational, social, and psychological outcomes of childhood obesity: a national birth cohort study. *Bmj*, 330(7504), p.1354.

4 Wadell G, Burton A. Is Work Good For Your Health and Well-Being? TSO (The Stationery Office), 2006.

5 Waddell, G. and Aylward, M., 2005. The scientific and conceptual basis of incapacity benefits. TSO.

6 Wang, M., Helgesson, M., Rahman, S., Niederkrotenthaler, T. and Mittendorfer-Rutz, E., 2017. Trajectories and characteristics of functional impairment before and after suicide attempt in young adults—a nationwide register-based cohort study. *BMC psychiatry*, 17(1), p.393.

7 Harvey SB, Modini M, Christensen H, Glozier N. Severe mental illness and work: what can we do to maximise the employment opportunities for individuals with psychosis? *Aust NZ J Psychiatry* 2013; 47: 421–4.

8 Wadell G, Burton A. Is Work Good For Your Health and Well-Being? TSO (The Stationery Office), 2006.

9 Bond GR. Supported employment: evidence for an evidence-based practice. *Psychiatr Rehabil J* 2004; 27: 345–59.

10 Bush PW, Drake RE, Xie H, McHugo GJ, Haslett WR. The long-term impact of employment on mental health service use and costs for persons with severe mental illness. *Psychiatr Serv* 2009; 60: 1024–31.

11 DWP and DHSC. The Employment of Disabled People 2019 (published March 2020)

12 Adult Social Care Outcomes Framework, England 2018-19

13 Boardman J. Work, Employment and psychiatric disability. *BJPsych Adv* 2003; 9: 327–334

14 DWP Stat-Xplore (February 2020). Note this does not include people on Universal Credit

15 Harvey SB, Modini M, Christensen H, Glozier N. Severe mental illness and work: what can we do to maximise the employment opportunities for individuals with psychosis? *Aust NZ J Psychiatry* 2013; 47: 421–4.

goals for life.<sup>16</sup> Across England, a CQC survey found that 47% of service users who wanted help to find work did not receive it. This figure is largely unchanged in the past six years.<sup>17</sup>

15. The employment rate for people with mental health problems is an outcome tracked under the Adult Social Care Outcomes Framework<sup>18</sup>, NHS Outcomes Framework<sup>19</sup>, and the Public Health Outcomes Framework<sup>20</sup>.
16. The total cost of mental health problems in England is calculated to be £105.2 billion. Of this, 29.9% (£23.1 billion) is linked to output losses that directly relate to the impact of mental health problems on people's ability to work.<sup>21</sup>
17. There is also a direct cost to local commissioners. Council Tax Support, a benefit funded by Local Authorities, is likely to be paid at a higher rate for people who are out of work. Providing effective employment support for people with severe mental illness can save the NHS around £6,000 through reduced use of secondary mental health services.<sup>22</sup>

*“A job provides money, social networks, relationships, confidence, satisfaction, personal fulfilment and a sense of achievement. This is what I am, and this is what I do. I am no longer a mental health condition.”*

– Man with severe mental illness<sup>23</sup>

*“Having a job gives me a reason to live. When working, I can show ‘I am like you, I am like others’. Especially because of the stigma in our community. Work is a lifesaver. It’s not the money, it’s therapeutic. You need a structure, rather than days in front of the xbox, you need to get out. I’m in control, but [Employment Specialist] is there to support me if I need him.”*

– Client referred to an IPS employment specialist<sup>24</sup>

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16 Secker J, Grove B, Seebohm P. Challenging barriers to employment, training and education for mental health clients: The client's perspective. *Journal of Mental Health* 2001; 10: 395–404; Dunn EC, Wewiorski NJ, Rogers ES. The meaning and importance of employment to people in recovery from serious mental illness: Results of a qualitative study. *Psychiatr. Rehabil. J* 2008; 32: 59–62

17 CQC Community mental health survey 2019 (England tables)

18 ASCOF Indicator Profile 1F: The percentage of adults in contact with secondary mental health services in paid employment

19 NHS Outcomes Indicator 2.5: Percentage point gap in employment rates between the general population and people with a mental illness

20 Public Health Outcomes Indicator 1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate

21 “The economic and social costs of mental health problems in 2009/10”, Centre for Mental Health (2010)

22 “Commissioning what works”, Centre for Mental Health Briefing Paper 41

23 “Job Well Done”, New Philanthropy Capital (Feb 2012)

24 Hutchinson et al. Implementing Supported Employment. Lessons from the Making IPS Work Project (unpublished)

## Evidence base for effective interventions

18. A wide range of interventions have been developed to support people with mental health problems and other conditions into work. These can broadly be categorised by their scope (i.e., systemic or individualised), their form (online, telephone, face-to-face) and their content (health improvement, preparation for employment, job brokerage, in-work support). However, few of these interventions have robust evidence to support their effectiveness for people with mental health problems.
19. The following sections outline the available evidence and value-for-money considerations for a range of employment support models. This aims to inform commissioning strategies on which models to invest in, and which to disinvest from.

### (1) Individual Placement and Support (IPS)

20. For people with **severe and enduring mental illness (SMI)**, who are in contact with secondary mental health services, there is a substantial international evidence base, substantiated by UK provider experience, that backs the effectiveness of the **Individual Placement and Support (IPS)** model of supported employment.
21. IPS is a person-centred, face-to-face model, defined by eight principles (see below). These focus on integrating employment support alongside health treatment; providing rapid, personalised job search; tailoring employer engagement to individual aspirations; and offering extended in-work support.
22. IPS is a well-defined variant of the broader category of supported employment interventions, sometimes called “place, train, and retain” in contrast to traditional “train and place” approaches. Traditional models tend to focus on preparing for work, which may include long periods spent in volunteering, training, or sheltered employment. By contrast, supported employment approaches focus on rapid vocational profiling (identifying skills, experience, aspirations, and required work adjustments), job search and brokerage, and then in-work support for both employer and service user.
23. Supported employment has been defined as “competitive work in integrated work settings...consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals, for individuals with the most significant disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a significant disability”<sup>25</sup>.
24. Supported employment, and specifically the IPS model, are recommended by NICE as part of treatment and recovery for adults with schizophrenia and other psychoses.<sup>26</sup> Increasing access to IPS services is a key strand of the NHS Long Term Plan. This committed the NHS to increasing access to IPS services for people with SMI from just under 10,000 per year in 2017 to 55,000 in 2023/24 and 115,000 in 2028/29.<sup>27</sup>

<sup>25</sup> [http://rwjms.rutgers.edu/boggscenter/projects/supported\\_employment.html](http://rwjms.rutgers.edu/boggscenter/projects/supported_employment.html)

<sup>26</sup> NICE guidance for psychosis and schizophrenia in adults – Quality statement 5 (Feb 2015)

<sup>27</sup> NHS Long Term Plan (Appendix)

25. There have been 28 international Randomised Control Trials (RCTs) of IPS. 27 of these found that IPS was significantly more effective at supporting people with severe mental illness into competitive employment than alternatives.<sup>28</sup> A lack of effective supported employment services has been cited as one of the key barriers for people with mental health problems to find work.<sup>29</sup> The research base for IPS includes:

- a. 12 US-based and 16 non-US-based RCTs with a total of nearly 6,500 participants. 17 of the 28 RCTs had at least an 18-month follow-up. 27 of these studies showed that people receiving IPS were significantly more likely to have found a job than those in the control group. Mean competitive employment rates for the 28 studies were<sup>30</sup>:
  - i. IPS: 55%
  - ii. Control group: 25%
- b. One of the largest European studies was a six-country trial. This found that participants receiving IPS had higher rates of job outcomes (54.5% versus 27.6% for traditional support); worked more hours; and remained in work for longer. It also found an 11 percentage point reduction in hospitalisation rates for people receiving IPS and a four point reduction in time spent in hospital.<sup>31</sup>
- c. A review of 19 Randomised Control Trials (RCTs), of which ten were from outside North America, found IPS to be more effective than traditional vocational rehabilitation “regardless of prevailing cultural or economic conditions”<sup>32</sup>;
- d. A review of 14 RCTs found that IPS increased employment levels, length of job sustainment, and reduced the time taken to get a job<sup>33</sup>;
- e. Long-term follow-up studies have found that “half of all clients enrolled in IPS become steady workers, maintaining employment for 10 years or longer. A recent follow-up study of a large, multisite trial found that significantly higher earnings for IPS clients compared to controls persisted over a five-year period after the two-year intervention”<sup>34</sup>;
- f. A review of IPS services in rural areas and different sized communities found no significant difference in employment outcomes,<sup>35</sup>

28 New IPS Research Findings (presentation). The IPS Employment Center. Available at <https://ipsworks.org/wp-content/uploads/2020/07/ips-evidence-5-29-20.pptx>

29 Boardman J, Rinaldi M. Difficulties in implementing supported employment for people with severe mental health problems. *Br J Psychiatry* 2013; 203: 247–249

30 New IPS Research Findings (presentation). The IPS Employment Center. The one study where IPS did not have an advantage over the control was in mainland China

31 “Getting Back to Work with psychosis: The European experience” – presentation by Professor Tom Burns, based on results of EQOLISE trial

32 Modini M, Tan L, Brinchmann B, Wang M-J, Killackey E, Glozier N. et al Supported employment for people with severe mental illness: systematic review and meta-analysis of the international evidence. *Br J Psychiatry* 2016; 209: 14-22

33 Supported employment for adults with severe mental illness (Review). Konishita et al. *Cochrane Database of Systematic Reviews* 2013, Issue 9.

34 Bond, G. R., Drake, R. E., & Becker, D. R. (2020). An update on Individual Placement and Support. *World Psychiatry*, 19, 390-391. The referenced study is Baller JB, Blyler CR, Bronnikov S, Xie H, Bond GR, Filion K, Hale T. Long-Term Follow-Up of a Randomized Trial of Supported Employment for SSDI Beneficiaries With Mental Illness. *Psychiatr Serv.* 2020 Mar 1;71(3):243-249

35 Luciano, A. E., Bond, G. R., Becker, D. R., & Drake, R. E. (2014). Is high fidelity to supported employment equally attainable in small and large communities? *Community Mental Health Journal*, 50, 46-50

- g. A recent meta analysis found that the efficacy of IPS is not impacted by macroeconomic conditions, such as the unemployment rate or GDP growth. This suggests IPS can still continue to be effective during recessions.<sup>36</sup>
26. A 25-point fidelity scale has been developed to measure IPS service quality and adherence to the eight principles. Evidence shows that a higher score on this scale is linked to improved job outcomes.<sup>37</sup>
27. Fidelity reviews should be conducted by an independent assessor to give an accurate score. Each fidelity review can take from one to two days. They involve gathering information from multiple sources, including service users, the delivery staff, commissioners and mental health clinicians and case records. The outcome is a report with a fidelity grade and any recommendations for improvement. A national fidelity framework has been proposed by the National IPS Expert Forum<sup>38</sup>. This sets out the recommended frequency and scope of independent Fidelity reviews. It also sets out how services can conduct guided self-assessments between external reviews. The framework is due to be published in late 2020.
28. Services that operate in line with the eight principles of IPS, as evidenced by fidelity reviews, tend to deliver better employment outcomes<sup>39</sup>, whereas services that operate with lower fidelity are associated with a lower success rate.<sup>40,41</sup>
29. Aside from fidelity, the competence, training, and experience of the IPS team leader and frontline staff are key factors in driving outcomes. UCL and the Royal College of Psychiatrists have developed a competence framework and curriculum for IPS employment specialists in collaboration with IPS Grow<sup>42</sup>.
30. The IPS evidence base suggests that several factors often considered relevant are not good predictors for job outcomes. These include:
- a. Individual diagnosis
  - b. Severity of health condition
  - c. Social skills
31. More relevant to likely success are client motivation, self-efficacy, and having an employment history: “Wanting to work and believing that you can are the best

<sup>36</sup> Brinchmann B, Widding-Havneraas T, Modini M, Rinaldi M, Moe CF, McDaid D, Park AL, Killackey E, Harvey SB, Mykletun A. A meta-regression of the impact of policy on the efficacy of individual placement and support. *Acta Psychiatr Scand*. 2020 Mar;141(3):206-220

<sup>37</sup> Bond, G. R., Becker, D. R., & Drake, R. E. (2011). Measurement of Fidelity of Implementation of Evidence-Based Practices: Case Example of the IPS Fidelity Scale and Kim et al (2015). Predictive validity of the Individual Placement and Support fidelity scale (IPS-25): A replication study

<sup>38</sup> The National IPS Expert Forum is an informal group, convened by IPS Grow, which brings together commissioners, policymakers, practitioners, and experts

<sup>39</sup> Drake R, Bond G, Becker DR. Individual Placement and Support: An Evidence-based Approach to Supported Employment. Evidence Based Practice Series OUP, 2012

<sup>40</sup> Bond GR, Drake RE, Becker DR. Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US. *World Psychiatry* 2012; 11: 32–9

<sup>41</sup> Lockett, H., Waghorn, G.; Kydd, R.; Chant, D. Predictive validity of evidence-based practices in supported employment: a systematic review and meta-analysis. *Mental Health Review Journal* 2016, 21, 261 – 281.

<sup>42</sup> Available at <https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-14> and <https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/ips/ips-competence-framework-and-curriculum-guide.pdf>

predictors of work outcomes.”<sup>43</sup> Other factors include education, perceived level of disability, job satisfaction, and timely and appropriate referral to rehabilitation services.<sup>44</sup>

32. Under IPS, most referrals will come from clinical staff in mental health teams. Co-location and other forms of integration between IPS specialists and clinical staff is critical to the success of this referral pathway.
33. **Value-for-money considerations.** IPS has been found to be cost-effective in multiple studies:
  - a. A Centre for Mental Health analysis showed that IPS could save around £6,000 per person in reduced use of mental health services, significantly greater than the cost per client<sup>45</sup>;
  - b. A cost-benefit study based on the 6-country EQOLISE trial found that IPS was more cost-effective than alternative models.<sup>46</sup>
34. **IPS capacity required.** As part of the NHS Long Term Plan planning process, each CCG has committed to access targets for IPS for people with SMI up to 2023/24. These local targets can be found in the [CCG LTP Ambitions Tool](#). IPS Grow has developed a [funding, workforce planning and outcomes calculator](#), which can help translate local access targets into funding and workforce requirements as well as recommended service outcomes.
35. Further considerations for commissioning IPS as part of Long Term Plan commitments are set out in the IPS Grow 5-step guide to commission IPS services to meet Long Term Plan commitments.
36. A bottom-up approach to estimating demand for IPS, based on underlying population drivers, might apply the following logic:
  - a. Total number of working age (16 years +) adults on caseload of secondary mental health teams;
  - b. Less the number of people who are already in paid employment. The percentage of people in contact with secondary mental health services in paid employment is recorded as part of the Mental Health Standard Data Set (MHSDS). Nationally, only 8% of people in this category are in paid work;
  - c. Multiplied by the percentage of people with severe mental illness who may be interested in seeking paid work in any one year. Note that this is the only exclusion criteria for IPS and is not the same as the percentage that clinicians or other professionals *believe* may be suitable for paid work. While there is no definitive view on the proportion who fall into this category, studies suggest it may be 30-50% of the cohort<sup>47</sup>.

<sup>43</sup> Individual placement and support: from research to practice. Miles Rinaldi, Rachel Perkins, et al. *Advances in Psychiatric Treatment* (2008), vol. 13, 50–60

<sup>44</sup> Waddell, G., Burton, A.K. and Kendall, N.A.S., 2016. *Vocational rehabilitation: what works, for whom, and when?* London: The Stationary Office; 2008.

<sup>45</sup> Commissioning what works. The economic and financial case for supported employment. Centre for Mental Health briefing note 41(2009)

<sup>46</sup> Supported employment: cost-effectiveness across six European sites. Knapp et al. *World psychiatry* 2013 Feb, 12 (1). pp. 60-68

<sup>47</sup> "Mental health and work", Royal College of Psychiatrists (2008)

37. Taking the lower end of this estimate, in an area with 2,000 people of working age on mental health service caseloads where 8% are employed, the total potential referral volumes to IPS in a year would be  $2,000 \times 92\% \times 30\% = 552$  potential referrals per year.
38. Typically, a fully-trained employment specialist can work with around 40 clients per year. In the above case, this suggests the area would need around 11 employment specialists (calculated as the number of potential referrals divided by the number of clients per employment specialist per year).
39. The average IPS team leader can supervise around five employment specialists. An area with 11 employment specialists would, therefore, require two full-time IPS Team Leaders.
40. **Enhancements to IPS.** While the core principles of IPS have been rigorously tested in numerous academic trials, some studies have considered adaptations or enhancements to the model. These include:
- a. **Time-limited support.** The IPS principle of time-unlimited support can significantly constrain the number of clients an IPS team can work with over time. One study showed that limiting support to nine months in total (or four months after an individual has found work) resulted in similar employment outcomes to full IPS but enabled the team to work with more clients. However, even in this study, individuals in work who needed to return to the service later on for support were able to do so if problems arose. This is important to maximise job sustainability<sup>48</sup>;
  - b. **Integrating job retention support.** Many established IPS services provide help both to people who are unemployed and to those who are in work, but either off sick or at risk of losing their jobs.<sup>49</sup> Although job retention support does not strictly conform to IPS fidelity principles, NHS England guidance indicates that up to 15% of caseloads could be job retention clients while still counting the service as delivering IPS;
  - c. **IPS with motivational interviewing.** One challenge with IPS is that it requires some degree of motivation from clients to seek paid employment. Indeed, this is the only exclusion criteria for the service. To address this, one study of IPS included training for clinical staff in motivational interviewing, a technique to help them address service user concerns about employment and overcome motivational conflicts. It found that this addition improved employment outcomes.<sup>50</sup> Further research is required to validate this finding;
  - d. **Peer support.** There is some evidence that peer support can be valuable in enabling people to gain and sustain employment.<sup>51,52</sup> In addition, a number of IPS services have employed some employment

48 Burns, T., Yeeles, K., Langford, O., Montes, M.V., Burgess, J. and Anderson, C., 2015. A randomised controlled trial of time-limited individual placement and support: IPS-LITE trial. *The British Journal of Psychiatry*, 207(4), pp.351-356.

49 Rinaldi, M., Miller, L. & Perkins, R. (2010) Implementing the individual placement and support (IPS) approach for people with mental health conditions in England, *International Review of Psychiatry*, 22(2), 163-172

50 Craig et al, 2014. Vocational rehabilitation in early psychosis: cluster randomised trial. *The British Journal of Psychiatry*

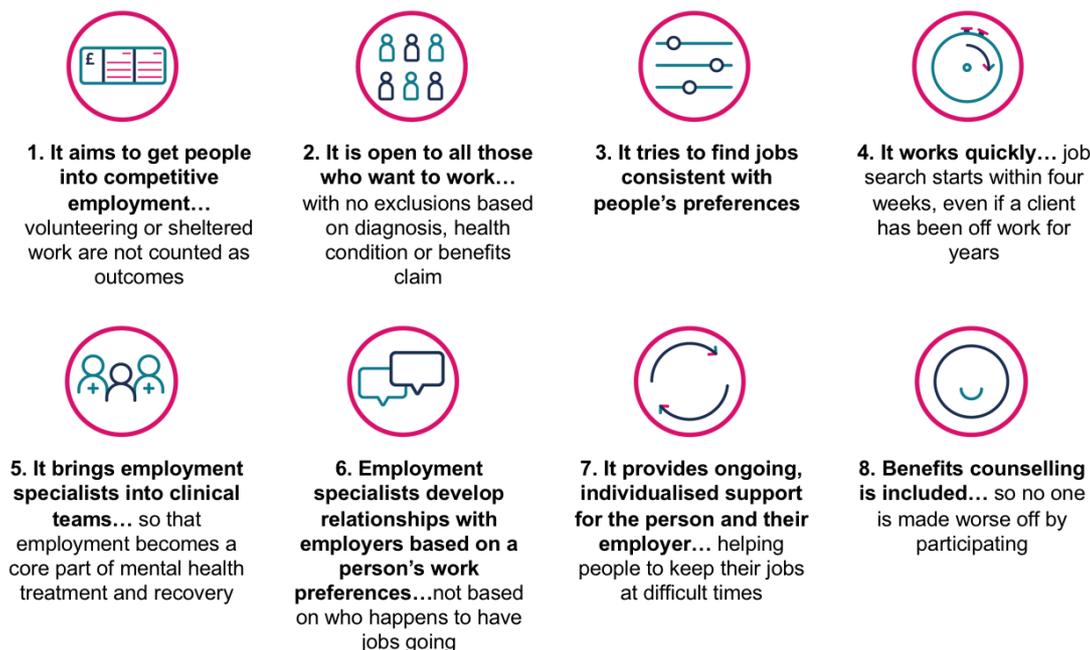
51 Sayce L and Fagelman N (2016) Peer Support for Employment: a Practice Review. London: Disability Rights UK

52 The Work Foundation and McEnhill L, Steadman K and Bajorek Z (2016) Peer Support for Employment: a Review of the Evidence. London: The Work Foundation and Disability Rights UK

specialists or team leaders who have lived experience of returning to work with a mental health problem.

41. Further technical detail on IPS is available as part of the IPS Grow suite of commissioning support documents. This is available at [www.ipsgrow.org.uk](http://www.ipsgrow.org.uk).

Figure 1. Eight principles of IPS



## (2) Employment advisers in primary and community care

42. In contrast to the research on IPS for people with severe mental illness, the evidence base for the effectiveness of these interventions for people with **common mental health problems** has been found to be limited.<sup>53</sup>
43. This is supported by the experience of the DWP Work Programme, where multiple providers were given flexibility to deliver different interventions to support people who were long-term unemployed back to work. Only 11% of people with mental health problems were supported into employment under this programme.<sup>54</sup>
44. The most promising areas of research and trialling borrow the principles of IPS and apply them to primary and community care settings. There is some emerging evidence to support this both internationally<sup>55</sup> and in the UK.
45. Trials are currently under way in the UK to test whether IPS can be effective for people with a range of health conditions who are accessing primary and community care services.<sup>56</sup>
46. Additionally, the government has committed to doubling the number of employment advisers embedded into IAPT primary care mental health teams. Although this programme does not strictly follow the principles of IPS, it furthers the integration of clinical treatment and vocational support. This programme is subject to a government-sponsored evaluation.<sup>57</sup>

53 "Psychological Wellbeing and Work", RAND Europe (2014)

54 "Improving Lives: The Work, Health and Disability Green Paper Mental Health Sector Response" (2017)

55 Effektevaluering av Individuell jobbstøtte (IPS): Sluttrapport (Dec 2016)

56 NHS Long Term Plan (2019)

57 Improving lives: the future of work, health and disability (DWP and DHSC, 2017)

47. **Number of employment advisers in IAPT required.** The original business case for IAPT proposed that there should be one employment adviser for every eight therapists. This aimed to ensure sufficient capacity in each IAPT team to support people to enter and retain employment as a critical part of their treatment and recovery programme. This 1:8 ratio continues to be the government target under its employment advisers in IAPT programme, subject to the evidence generated by ongoing trials.<sup>58</sup>

### (3) Other models currently being trialled

48. A report by RAND Europe on “Psychological Wellbeing and Work” for DWP and Department of Health (DH) outlined four high-potential interventions for people with mental illness<sup>59</sup>:

- a. IPS in primary care
- b. Group work, based on the JOBS II model tested in other countries
- c. Online support
- d. Telephone support

49. Based on this report, all four models were tested in short trials in 2014/15. Since then, several additional trials of IPS in primary and community care have launched (see above).

50. Additionally, DWP and DH are piloting the group work model in Jobcentre Plus. Group work is a voluntary programme involving a week-long set of facilitated discussions between a group of job seekers. This trial launched in 2017 with the final evaluation due in 2019.<sup>60</sup>

### (4) Social enterprises and sheltered work

51. Alternative approaches to recovery include day services, psychosocial rehabilitation, and sheltered employment (for example, in social enterprises funded to provide employment for people with mental health problems). However, evidence suggests these models do not help individuals move into paid work and do not offer the same beneficial impact as paid employment for their users. They are also typically high cost per user, since they typically work with a relatively small number of users over a long period of time.

52. One early study of supported employment showed that day treatment services that converted into supported employment services achieved a doubling of the rate at which clients were supported into work (38% versus 15% for day services that did not convert). The same study found that “day treatment, sheltered employment, and other approaches lacking a competitive employment focus, do not contribute to and may interfere with the goal of competitive employment”.<sup>61</sup>

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<sup>58</sup> Ibid

<sup>59</sup> “Psychological Wellbeing and Work”, RAND Europe (2014)

<sup>60</sup> “Improving Lives: The Future of Work, Health and Disability”, DWP and DH (Nov 2017)

<sup>61</sup> Supported employment: evidence for an evidence-based practice. Gary R. Bond, *Psychiatric Rehabilitation Journal*; Spring 2004; 27,4

53. Sheltered employment, for example through social enterprises funded to provide jobs to a specific cohort, has been found to significantly reduce the likelihood of individuals finding a competitive job. This has been validated in both UK and US studies.<sup>62</sup>In general, evidence from the US shows that programmes with a smaller job preparation component deliver better job outcomes.<sup>63</sup>
54. Some advocates of sheltered employment argue that, even if individuals are less likely to get competitive jobs, their sheltered work offers similar wellbeing benefits as jobs found in the open market. However, while competitive work is clearly associated with improved quality of life and reduced symptoms, there is little or no evidence that these outcomes are achieved for people in sheltered employment.<sup>64</sup>

### Other existing provision

55. Employment support has always been commissioned and funded by a range of actors in the UK, including DWP, Local Authorities, NHS Clinical Commissioning Groups, European Social Fund, Big Lottery Fund, and donor- or grant-funded charities. This has led to a patchwork of service provision with different referral pathways, eligibility criteria, and delivery approaches.
56. The diagramme below highlights the key programmes offering support in 2020.
- a. *Jobcentre Plus (JCP)* is DWP's primary delivery arm for both benefits processing and back-to-work support. It provides a large variety of support services, including Universal Jobmatch, face-to-face support from a work coach, workshops, group session, and other support;
  - b. *Access to Work* is a DWP programme that provides a range of support options for individuals who need extra support or equipment to remain in work. This could include physical tools, adaptations, software, or personal support workers for people with physical impairments or mental health difficulties. *Access to Work* is available for people who either have a paid job or are about to start or return to one. This could include a work trial, internship, or apprenticeship. *Access to Work* could be used to provide ongoing support for people with a mental health problem as part of an IPS service model, though this has not been tested to date;
  - c. *Fit For Work* is an online offer that provides information and guidance to individuals who are in work, either struggling with a health condition or on a period of sickness absence;
  - d. *Work and Health Programme* is DWP's primary contracted-out welfare-to-work offer for individuals who are long-term unemployed or are out of work with a health condition. It is delivered by a mixture of social enterprises, charities, and private contractors, each offering a range of services to support people back into work;

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<sup>62</sup> Ibid

<sup>63</sup> Ibid

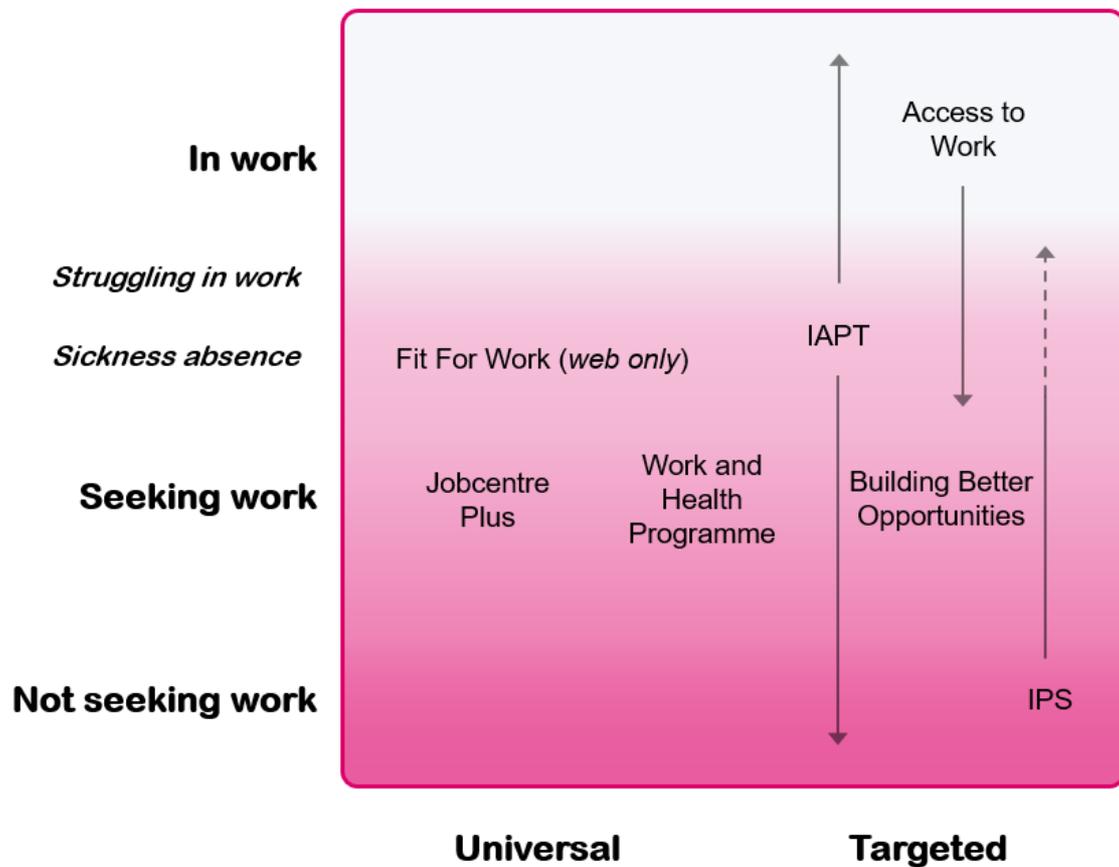
<sup>64</sup> Individual placement and support: from research to practice. Miles Rinaldi, Rachel Perkins, et al. *Advances in Psychiatric Treatment* (2008), vol. 13, 50–60

- e. *Building Better Opportunities (BBO)* is a European Social Fund (ESF)-funded programme, match-funded and administered by Big Lottery Fund (BLF). It has funded a range of local programmes targeted at cohorts with disabilities, health conditions and other barriers to employment;
- f. *Improving Access to Psychological Therapies (IAPT)* is a key part of NHS-funded primary care support for people with common mental health problems. Although few IAPT services offer employment support today, the government has committed to doubling the number of employment advisers embedded in IAPT services. This aims to achieve a 1:8 ratio between employment advisers and therapists in 40% of CCG-commissioned IAPT services. In addition, the government is running a number of trials to determine the effectiveness of embedding IPS-trained employment specialists in IAPT services;
- g. *Individual Placement and Support (IPS)* is a well-defined, evidence-based form of supported employment. While it has traditionally been focused on people with severe mental illness who are in contact with secondary mental health services, the government is trialling extending the principles of IPS into primary and community care settings.

57. In addition to these, the government has announced funding for additional employment support programmes in response to the rise in unemployment linked to Covid-19. These include the *Job Entry Targeted Support (JETS)* programme, targeting people out of work for three months, and *Kickstart*, a job placement scheme for young people aged 16-24.

58. Given the diversity of provision across the UK, local commissioners will need to develop their own strategies for ensuring a coherent offer is available in their areas. In some cases, this may lead to de-commissioning of services that lack an evidence base in order to divert funding towards evidence-based provision.

Figure 2. Overview of key employment support services



## Role of clinical teams

59. Clinical teams have a vital role to play in supporting the vocational outcomes of people with mental health problems. They can:

- Check whether service users are in work and adjust their treatment programme accordingly, for example by making treatment relevant for their employment context or just by scheduling appointments outside of the user's work day;
- Have meaningful conversations with their service users about the role of paid work in their recovery;
- Refer individuals into relevant employment services;
- Work with employment services to provide "shared care" for the user.

60. The IPS approach was developed against a background where treatment as usual tended to focus on clinical outcomes, such as the reduction of symptoms of mental illness, and the promotion of a gentle progression towards achieving mental stability and consolidation of personal strengths. However, the evidence demonstrates that when clinicians defer conversations and encouragement regarding employment opportunities until this perceived level of "recovery" and

“work readiness” has been reached, there will be many fewer vocational outcomes achieved overall.

61. Commissioners should seek to gain maximum buy-in for employment support at all levels of management and frontline delivery at the relevant health services.

They can support integration through:

- a. Partnership agreements between the commissioner(s), clinical team(s), and employment service provider(s);
- b. Requiring clinicians to be trained in understanding the role of employment in recovery and in different techniques to talk to service users about work;
- c. Monitoring health teams on vocational as well as clinical outcomes.

*“Nowadays my psychiatrist and psychologist are eager to discuss my employment situation with me, particularly how I can manage this to prevent an exacerbation of my mental health problems. This has been a very helpful strategy, particularly when I have been an inpatient and needed to agree a staggered return to work, but also on a day-to-day basis.”*

– Client referred to an IPS employment specialist<sup>65</sup>

## Role of employers

62. The supported employment model emphasises the need to match job opportunities to client aspirations. This tends to work best when employment specialists engage employers at an individual level, focusing their activity on employers that are most likely to offer roles suited to their specific clients. Once individuals are in work, employment specialists support both the employer and the employee in order to sustain the work placement.
63. Commissioners can, however, facilitate local employer engagement, for example by working with Chambers of Commerce and other employer groups and networks to encourage employers to make themselves more accessible to people with mental health problems. This could be by signing up to Disability Confident<sup>66</sup> or other campaigns or creating alternative recruitment routes that by-pass standardised processes that might automatically or incidentally screen out people with health conditions.
64. In addition, [Thriving at Work](#), the Stevenson/Farmer report highlighted the need for public sector employers to act as role models by creating routes to employment for people with mental health problems. Public sector employers often have complex and risk-averse recruitment processes that put up barriers for people with mental health problems. Best-in-class organisations have user employment programmes that actively work with employment support services to identify opportunities for those who have been users of the service to find employment in the organisation. For example, a mental health trust with an IPS service could find ways to facilitate the employment of IPS clients in the trust.

## Resources

65. Additional information on Individual Placement and Support (IPS) can be found from:
- a. **IPS Grow** ([www.IPSGrow.org.uk](http://www.IPSGrow.org.uk)): This includes a comprehensive set of materials to support commissioning, operational delivery, workforce development, and reporting;
  - b. **Centre for Mental Health** ([www.CentreforMentalHealth.org.uk](http://www.CentreforMentalHealth.org.uk)): This includes a set of briefings that cover the cost-benefit case for IPS, more detail on the IPS model, and case studies of how the model has been extended to different cohorts, such as people with addictions;
  - c. **IPS Works** ([www.IPSWorks.org](http://www.IPSWorks.org)): IPS Works is the leading centre for IPS research and support in the US. It provides online trainings for employment specialists and team leaders, as well as links to the evidence base for IPS.
66. Additional information on other models of support for people with mental health problems can be found from the following:
- a. “Improving Lives: The future of work, health and disability”, DWP/DH (Nov 2017)
  - b. “Psychological Work and Wellbeing”, RAND Europe (Jan 2014)

<sup>66</sup> <https://www.gov.uk/government/collections/disability-confident-campaign>

- c. “Realising ambitions: Better employment support for people with a mental health condition”, DWP (Dec 2009)
- d. “Vocational services for people with severe mental health problems: Commissioning guidance”, DWP and DH (Feb 2006)

67. Further information on work and mental health can be found at the **Royal College of Psychiatrists** web page:  
[www.rcpsych.ac.uk/usefulresources/workandmentalhealth.aspx](http://www.rcpsych.ac.uk/usefulresources/workandmentalhealth.aspx)