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Employment Advisers in Improving Access to Psychological Therapies: Process Evaluation Report

ICF, IFF Research

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Executive summary

This report provides findings from the Process Evaluation of the Employment Advisers in Improving Access to Psychological Therapies (EAs in IAPT) programme. This programme is funded by the Work and Health Unit (WHU)[1] to provide resource for an additional 350 EAs within IAPT services. To explore whether the investment improves work and health outcomes, the programme has been piloted across 40 per cent of Clinical Commissioning Groups (CCGs), split in to two waves. IAPT services in Wave 1 CCGs recruited their EAs to work with clients from 01 March 2018, whilst EAs in Wave 2 sites received investment later so that their EAs were in place to see clients from 01 March 2019. This report draws on qualitative evidence from eight Wave 1 case studies of local programmes.

Findings from the case studies indicate that the programme has been **well-received by clients, therapists and employability partners and fills important gaps in local provision.** Clients commonly present with employment-related issues and timely EA intervention can support improvements in clients' mental well-being. Staff report positive early outcomes for clients including: increased confidence, assertiveness and motivation; improved mental health and well-being; a return to work or movement to alternative employment; and progress into or towards work.

The report identifies a number of facilitating factors supporting the setup of effective EA in IAPT services that future local programmes may wish to consider:

- Early appointment of Senior Employment Advisers (SEAs) to give them time to play an active role in recruitment and service design.
- Recruitment of EAs with a range of skills and experience, including both employment support and working with clients with mental health problems.
- Integration of EAs and therapists facilitated by co-location and strong channels of communication. Where EAs are working in community locations, proactive communication is particularly important, for example, joint meetings, shadowing, informal get-togethers.
- Putting in place a robust plan for how EAs will be supported and developed with clear expectations of the role and protocols in place to ensure professional boundaries do not become blurred.
- Developing strategic links between IAPT service providers and employability partners (e.g. Jobcentres, local authorities). These provide opportunities for referral, raising awareness of the links between mental health and employment and avoiding replication of provision.

[1] The WHU is a UK government Joint Unit between the Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC). It leads on the Government's strategy to support working-age disabled people or those with long-term conditions, to access and retain good quality employment.

Contents

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Glossary of terms

Advisory, Conciliation and Arbitration Service (ACAS) – Non-departmental public body designed to improve organisations and working life through the promotion and facilitation of strong industrial relations practice.

Clinical Lead – Clinician taking lead responsibility for the clinical aspects of a service and who bears the responsibility for clinical governance and ensuring high standards of clinical care and service delivery.

Improving Access to Psychological Therapies (IAPT) – Programme that began in 2008. Local CCGs commission services that provide evidence-based psychological therapies to people with anxiety disorders and depression.

Individual Placement and Support (IPS) – Provides intensive, individual support to people with severe mental health difficulties to help them to move towards and into employment.

Employment Adviser (EA) – Person providing a range of support and advice on issues related to employment to clients who are in and out of work.

Employability partners – Refers here to stakeholders from organisations delivering employment support and advice who work collaboratively with EA in IAPT services.

IAPTUS – Case management software system for clients receiving psychological therapies.

PCMIS – Case management software system for clients receiving psychological therapies.

Reasonable adjustments – Refers to changes made to the work environment to remove barriers or disadvantages that enable people with a disability to work safely and productively. Under the Equal Opportunity Act 2010, 'disability' includes: physical, psychological or neurological disease or disorder, illness, whether temporary or permanent.

Service Lead – Post-holder leading a service with overall responsibility for its delivery.

Service Provider – Contracted organisation that provides services on behalf of a CCG.

Work and Health Unit (WHU) - The WHU is a UK government Joint Unit between the Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC). It leads on the Government's strategy to support working-age disabled people or those with long-term conditions, to access and retain good quality employment.

Abbreviations

ACAS Advisory, Conciliation and Arbitration Service

CCG Clinical Commissioning Group

DHSC Department of Health and Social Care

DWP Department for Work and Pensions

EA Employment Adviser

IAPT Improving Access to Psychological Therapies

IPS Individual Placement and Support

SEA Senior Employment Adviser

WAP Wellness Action Plan

WHU Work and Health Unit

WRAP Wellness Recovery in Employment Action Plan

Summary

Background and Methodology

This report forms part of the evaluation of the Employment Advisers in Improving Access to Psychological Therapies (EAs in IAPT) programme. EAs in IAPT is funded by the Work and Health Unit (WHU) to provide combined psychological support and employment advice to enable IAPT clients to stay in or take up work. The service is delivered by Employment Advisers (EAs) who are supported and managed by Senior Employment Advisers (SEAs) who also carry a small case load. Clients typically fall in to one of three categories: in work but struggling; in work but off sick; or out of work.

The WHU has provided funding for approximately 350 additional EAs. The programme has been piloted across IAPT services in 40 per cent of Clinical Commissioning Groups (CCGs), split in to two waves. IAPT services in CCGs in Wave 1 recruited their EAs so that they were ready to see clients from 01 March 2018, whilst EAs in Wave 2 sites received investment later so that their EAs were in place to start to see clients on 01 March 2019.

The case study findings presented in this report form part of a broader mixed methods process and impact study of the EAs in IAPT programme. Eight case study areas from Wave 1 are included, selected by CCGs to achieve coverage by region, rural/urban and relative deprivation score. To gain a rounded perspective on service implementation, a total of 91 qualitative interviews with Clinical Leads, therapists, managers, EAs, SEAs and employability partners were completed.

The purpose of this report is to provide feedback on the design and early implementation of EAs in IAPT and produce recommendations to Wave 2 sites based on this learning.

Main Case Study Findings

Service design and early implementation (Section 3)

The case studies included a mix of provider arrangements: five where the EAs were employed directly by the IAPT provider, two where they were employed by an employment advice provider, and one that was delivered through a not-for-profit healthcare provider commissioned by the IAPT service.

Recruitment: All areas except one experienced challenges in recruiting EAs and SEAs, with some having to advertise multiple times before the right staff could be appointed. EAs came from diverse backgrounds and sometimes did not have

experience delivering both mental health and employment support, as finding people with a combination of the two proved difficult. However, all local programmes were confident that they had managed to recruit competent teams with a wide range of appropriate skills and experience. Appointing experienced SEAs ahead of EAs was identified as the optimum arrangement as it facilitated the recruitment process and gave SEAs lead-in time to design induction and training programmes for new recruits. Where SEAs and EAs were appointed at the same time, SEAs had a limited role in recruitment and had to learn systems and processes alongside them.

Training: Teams needed to learn quickly and 'on the job'. This was particularly true for EAs without previous experience of delivering employment support. The national training offer was not available when Wave 1 went live, and this was a disappointment to some EAs, who explained that they had viewed this as an important component of future career advancement[2]. Local programmes had established their own packages of training augmented by opportunities to shadow senior staff and on-going SEA and peer support.

Service design and early set up: This was commonly led by the SEAs and involved establishing the client pathway and associated policies, paperwork and processes. National guidance was described as 'brief', but this was not necessarily problematic and was welcomed by many as offering flexibility and promoting innovation. The downside for some was that a period of intense work was required to get processes in place before programme launch. The importance of having an experienced SEA or dedicated Service Manager in post early was emphasised.

Assessment and early engagement: Client pathways across case studies were broadly similar, although there were some differences in when and for how long clients would enter the EA service. All programmes had established processes whereby therapists would refer clients to EAs following an initial assessment of their therapeutic and employment support needs. In some areas, clients could start employment support following assessment but prior to starting therapy, while in others there was the prerequisite of therapy first. Programmes of employment support varied widely in the length of time they expected to see clients, with two setting an initial standard of six weeks[3], one reporting that they would see clients for up to six months while others applied no time limit. Establishing protocols for working with clients who were no longer in therapy was important to ensure professional boundaries were not crossed and EAs were properly supported.

EA capacity: Local programmes were confident that they had employed the right number of EAs. Maximum active caseloads were typically set at between 25 and 30, although in most areas EAs were currently working at below capacity with the expectation that caseloads would grow as the service became embedded.

Referrals: These increased from a fairly low starting position (reports varied from between 4-5 to 10-15 referrals per month) as awareness and confidence in new services grew amongst therapists. Most teams had taken a proactive approach to

[2] The training programme was rolled out from March 2019.
[3] Note however that this was extended once the programme became more established.

promoting their work through publicity, outreach and exploiting opportunities for shadowing, joint meetings and working alongside therapy teams. Positive feedback from clients to therapists and co-location of EAs and IAPT services were key factors in promoting referrals.

Delivering the EAs in IAPT service in practice (Section 4)

All programmes were supporting a mix of people who are either in work but struggling; in work but off sick; or out of work. Some were working almost exclusively with in work clients, while others reported a more even split. Following referral, the EA would typically work with the client to co-design a bespoke package of support tailored to their individual needs. Where appropriate, therapists could be involved with designing elements of this. EA support could range from very light touch email and/or telephone contact to extended face-to-face support.

Support for clients in work but off-sick: EAs often attended return to work meetings with clients and provided a point of mediation between clients and their employers. Support was provided to help to build relationships; negotiate reasonable adjustments; advise on employment rights; and work in collaboration with therapists to build assertiveness and identify solutions to workplace challenges and stressors. In some cases, EAs also helped clients to seek alternative employment where a return to their current workplace was not seen as an appropriate solution.

Support for clients in work but struggling: This commonly included: building relationships with employers, helping to negotiate reasonable adjustments, mediating between clients and employers, advising on employment rights and working with therapists on confidence and skills such as assertiveness.

Support for out of work clients: EAs worked in tandem with therapists on self-esteem, confidence and assertiveness; and provided practical support with CV writing, job search and interview skills.

Integration of employment support with IAPT: Physical co-location was important for promoting integrated working between EAs and therapists. A shared working environment facilitated the growth of trusting relationships and broke down fears around ‘stepping on toes’ and professional mistrust. Being in the same office also provided opportunities for closer collaboration, allowing dovetailing of therapist and EA support to clients.

Working with local partners: Some areas had established strategic partnerships concerned with employment and health that preceded the EAs in IAPT programme. There were numerous examples of collaborative working at the delivery level. These included: Jobcentre Plus (JCP) and local welfare advisers delivering training to EAs on benefits; EAs shadowing colleagues at JCP; and IAPT therapists delivering training to JCP staff.

Benefits and early outcomes (Section 5)

There was a high level of support for the EAs in IAPT programme across all stakeholder groups. Interviewees described benefits and outcomes at three levels: for partner organisations; for the IAPT service; and for clients.

Benefits for employability partners: Respondents highlighted two key benefits for employability partners: 1) filling gaps in service provision, in particular for clients with common mental health problems who need support to retain employment; and 2) providing support to partner organisations in dealing with mental health issues.

Benefits and outcomes for IAPT services: A number of benefits for IAPT services were described: 1) EA support has enabled therapist time to be freed up to focus more directly on providing therapy; 2) in two areas immediate access to an EA has reportedly reduced waiting times by enabling therapists to work more effectively and efficiently with clients and spend less time dealing directly with employment concerns; 3) reduced burn-out amongst therapists was reported in two sites; and 4) by offering in-house one-stop shop provision, therapists were kept informed of the detail of the support that clients are receiving from EAs (in contrast to earlier signposting efforts).

Benefits and outcomes for clients: A wide range of both affective and practical outcomes for clients were described by EAs and SEAs. Affective outcomes included: increased levels of confidence, assertiveness and motivation; better problem solving, and improved mental health and wellbeing. 'Hard' outcomes included: remaining or returning to work with improved working conditions and negotiated reasonable adjustments; moving to alternative employment where this was a better option; and progress into and towards work.

Conclusions and recommendations (Section 6)

The EAs in IAPT programme has been well-received by therapists and employability partners and fills important gaps in employment support for people experiencing common mental health problems. Within the case study areas, the programme has added considerable increased capacity to deliver employment support to people accessing IAPT services. Local programmes are delivering integrated employment and therapeutic support to clients both in and out of work, and there is evidence of early positive outcomes.

Recommendations for Wave 2 areas

1) **Employ experienced SEAs prior to launch to lead recruitment and design of delivery models.** Set clear milestones and establish a timetable for setting up the service at the outset.

2) **Consider the optimum local arrangements for client referral to and exit from EA support.** For example, sites should establish clear protocols for working with clients who are not receiving therapeutic support.

3) **Set clear expectations for EAs.** While programmes need flexibility to develop a service model that is appropriate for their local context, EAs should have clear guidelines around what is expected of them in terms of the way they should work. For example, EAs need clarity about when it is appropriate to work face-to-face or by phone, and when to refer clients back to the therapist.

4) **Employ staff with a range of experience and skills.** Services should aim to employ SEAs with experience of both employment support and working with clients with mental health problems.

5) **Provide development and on-going support of EAs.** Services should consider opportunities for less experienced staff to shadow SEAs, establish mechanisms for case review, and be aware of any on-going training needs. Employment law and common mental health problems were most commonly identified by Wave 1 stakeholders as important issues to cover in training. On-going development is particularly important given the challenge of recruiting staff with experience of providing employment support to the IAPT client group.

6) **Support integration of EAs with therapists.** Co-location represents the optimum arrangement for supporting integration between EAs and therapists, facilitating relationship building between clinicians and EAs, while enabling clients to receive support in a single location. Even where co-location is achieved it is important to establish and maintain multiple opportunities for communication including, for example, team meetings, joint training, informal lunches and newsletters.

7) **Actively promote referrals.** Services should promote the EA service in IAPT and amongst relevant employability partners. To further promote referrals, the process should be made as simple as possible.

8) **Establish collaborative partnerships.** This should be done across local organisations to promote mutual referral and prevent replication.

9) **Consider developing 'off-the-shelf' resources for EAs.** For example, a directory of local support agencies, a list of websites that EAs can refer to and a set of fact-sheets covering key issues such as employment rights.

1 Introduction

The Employment Advisers (EAs) in Improving Access to Psychological Therapies (IAPT) programme is funded by the Work and Health Unit (WHU) to provide integrated psychological and employment support to enable people to stay in or take up work. In 2017, WHU commissioned IFF Research, in partnership with ICF, Bryson Purdon Social Research (BPSR) and the School of Health and Related Research (ScHARR) at Sheffield University, to undertake a process and impact evaluation of the EAs in IAPT programme.

This report provides formative findings from the qualitative component of the evaluation of the EAs in IAPT programme. It draws on evidence from a series of eight case studies of Wave 1 EAs in IAPT services delivered across a range of CCGs, selected to achieve a broad geographical and demographic representation. Fieldwork was undertaken between August and November 2018 and is being followed up by a series of longitudinal qualitative interviews with clients accessing EAs in IAPT services commencing in March 2019.

1.1 The EAs in IAPT programme

The IAPT programme was established in 2008 and has since grown rapidly, providing evidence-based therapies to adults with anxiety disorders and/or depression.

In 2009, an EA pilot pathfinder programme was introduced in 11 areas in IAPT services across England, which set out to test the benefits of offering employment support to help IAPT clients remain in or return to work. Shortly after its inception in 2015, WHU secured funding to extend the employment advice component of IAPT provision.

The programme adds additional capacity to deliver employment support to the target areas, by funding 350 additional EA posts in IAPT services across 40 per cent of CCGs in England over a three-year period. The original IAPT business case recommended a 1:8 ratio between EAs and Therapists and the additional funding seeks to bring the EA to therapist ratio closer to 1:8. The service has been designed to be managed and coordinated through the appointment of Senior Employment Advisers (SEAs) with the aim of ensuring that there is one SEA for up to a maximum of six EAs. The programme is being rolled out in two waves: Wave 1 went live in March 2018 and Wave 2 in March 2019.

The EAs in IAPT delivery model has been designed as an integrated service that brings together employment advice and support with IAPT provision. Therapists and EAs are expected to work collaboratively to deliver a personalised service to clients based on their individual needs. The service is designed to support people with common mental health conditions who are either:

- In work but struggling;
- In work but off sick/suspended from work; or
- Out of work.

Participation in employment support is voluntary and can be accessed at any point in the client journey from referral to discharge. Following assessment by a therapist, clients referred to the IAPT service are intended to follow one of three pathways according to their needs:

1. Therapeutic treatment only;
2. Therapeutic treatment and employment support simultaneously;
3. Employment support after their therapeutic treatment has been completed.

The approach is client-led so that if there are no pressing employment concerns, only therapeutic treatment will be offered. If employment support is clearly indicated at the outset, pathway two would be followed and if it only emerges later (just prior to discharge from IAPT treatment) that employment is an issue, then pathway three would be followed.

As well as delivering an integrated employment advice and therapy service to the target group, the programme aims to contribute towards a wider systemic and cultural change, whereby structural barriers to integrated working around employment and health are challenged. At the local level the intention is to support change through developing collaborative working relationships between EAs in IAPT providers and local employers, trade unions, Jobcentre Plus (JCP) and other organisations within the local labour market.

1.2 The evaluation approach

The case study findings presented in this report form part of a broader mixed methods study of the EAs in IAPT programme.

In addition to the case studies, the evaluation explores the outcomes and impacts that can be attributed to the programme through the following:

- Client surveys at two time points: A Wave 1 survey at two points following clients who have both received and not received employment support. These surveys will provide evidence of how a larger sample of clients have experienced employment support as well as the achievement of health, wellbeing and employment outcomes.
- An analysis of the impact of the EAs in IAPT investment using IAPT administrative data. This will compare client outcomes in Waves 1 and 2 over the course of the evaluation period (2018-19).
- Longitudinal client interviews with a sample of 60 clients at Time 1 (March-April 2019) and 40 at Time 2 (from September 2019), where possible following those clients who were interviewed at Time 1.

The evaluation began with a scoping phase designed to inform and develop the evaluation team's understanding of the programme, refine the evaluation approach and develop a programme level theory of change (ToC) logic model. A review of the evidence for integrated work-related advice and support interventions for people with common mental health conditions was also undertaken by ScHARR at Sheffield University.

The evaluation has been subject to ethical approval on a CCG by CCG basis. All interviewees have seen a Client Information Sheet with detail on the purposes of the evaluation and the reasons for data collection. They have also been made aware of their data subject rights.

1.2.1 Data collection for this report

Fieldwork was undertaken in eight case study areas between August and November 2018. The case study areas were selected from a possible 40 CCGs participating in Wave 1 of the programme. These were as follows:

- Buckinghamshire CCG (rural).
- Camden CCG (urban).
- City and Hackney CCG (urban).
- Dorset CCG (urban/rural).
- East Riding of Yorkshire CCG (urban/rural).
- Leicester City CCG (urban).
- Nottingham and Nottinghamshire CCGs (urban/rural)
- St Helen's CCG (urban).

A purposive sampling approach was taken to maximise the opportunity for findings to be transferable to other settings, allowing for exploration of contextual factors and common enablers and challenges.

CCGs were chosen from across each of the four NHS England (NHSE) regions and included a mix of rural, urban and combined rural/urban areas (as described at local authority level). Selection included a mix of highly and less deprived areas as defined by the 2015 English Indices of Deprivation. As a relative measure, 'high deprivation' was taken to include those CCGs sitting within the upper quartile of the deprivation index, and 'low deprivation' as those within the lower quartile. Case studies were selected against a range of Indices of Multiple Deprivation (IMD) scores to include low, high and moderately-deprived areas. The sample was agreed with WHU and where chosen areas did not give consent to participate (n=2), substitute areas with similar characteristics were selected.

Qualitative face-to-face interviews and focus groups were carried out with SEAs, EAs, therapists, Clinical Leads and Service Managers (see Table 2.1 below). Interviews were designed to explore the following key themes:

- Perspectives on the rationale, design and delivery of the programme;
- Progress with early set up and implementation, including challenges and enabling factors;
- Detail of the local delivery model;
- Any benefits and early outcomes for both clients and the wider system; and
- Learning and recommendations for roll out to Wave 2.

In some case study areas all EAs and SEAs were interviewed, while in others a majority sample was chosen based on a combination of their availability and willingness to take part. Therapists were also interviewed on the basis of willingness and capacity during fieldwork.

Telephone interviews with employability partners from a range of organisations were also undertaken. These were identified in consultation with local programmes on the basis that they had had most interaction with the service and were therefore able to comment on issues related to joint working. A total of 91 interviews were carried out across the eight case study sites as set out in table 2.1 below.

Table 1.1 Interviews undertaken across the eight case studies

Stakeholder Group	*Number of interviews*
Senior Employment Advisers (SEAs)	13
Employment Advisers (EAs)	29
Clinical Leads	7
Therapists	21
Service Leads/managers	8
Employability partners	13
Total	**91**

1.2.2 Data analysis

All interviews were recorded, with participant consent, and fully transcribed. Transcriptions were coded and analysed thematically using a framework analysis approach. Framework analysis is a systematic approach to analysing qualitative data. The approach enables the identification of common themes, and the differences and relationships between them, in order to draw explanatory conclusions clustered around key areas of interest[4]. The approach is particularly useful in the

[4] Developed by Jane Richie and Liz Spencer for use in large scale policy research, the approach utilises a matrix output: rows (cases – usually an individual research participant), columns (codes), and 'cells' of summarised data. This provides a structure into which the researcher can systematically reduce the data, in order to analyse it by case and by code.

analysis of semi-structured interviews and when multiple researchers are working on projects that involve large amounts of qualitative data.

Following framework analysis, each case study was analysed separately with this report bringing together the findings under thematic headings. These have not been included in this format in order to protect confidentiality and anonymity.

1.3 Structure and purpose of the report

The purpose of this report is twofold:

1) To provide a source of feedback, concentrating upon the design and early implementation of EAs in IAPT across eight case study local programmes.
2) To provide recommendations for Wave 2 sites based on learning gathered from the experience of the Wave 1 case studies.

Following this introduction, the report is structured into four sections:

- Section 3 providing an overview of the case studies included in the evaluation; stakeholder experiences of design and early implementation; and the key features of their delivery models.
- Section 4 covering the nature of EA support local programmes are providing to clients; what factors support the integration of EAs within IAPT services; and partnership work with local organisations.
- Section 5 exploring early outcomes for organisations, IAPT services and clients; and
- Section 6 setting out conclusions and recommendations for Wave 2 sites.

2 Case Study Findings: Service Design and Early Implementation

This section reviews the findings from the case study fieldwork, providing an overview of the eight case study areas, including the delivery models followed, and their experiences of establishing employment advice services.

2.1 Service design and set-up

2.1.1 Commissioning and early set up

Six of the eight case study CCGs had commissioned their existing IAPT provider to deliver the new or enhanced EA service 'in-house' (see Table 2.1). Five of these IAPT services were NHS-led with the sixth delivered through a not-for-profit health care provider. The latter had developed a partnership arrangement with a specialist employment provider enabling staff to be seconded into the IAPT service to deliver the EA component.

Two of the eight areas had commissioned external independent providers to deliver the EA offer. In both cases, the commissioned provider was a third sector organisation specialising in delivering a range of services, including employment support, to people with mental health problems. Both providers had previously been commissioned to provide a smaller scale employment support service for people with mental health problems and, following an open procurement process, were successful in winning the new contracts.

Table 2.1 Overview of EAs in IAPT case study CCGs

IAPT Service	EA provider model	Description of area covered
Oxford Health NHS Foundation Trust: 'Buckinghamshire Healthy Minds'.	Delivered through commissioned specialist employment/mental health support provider: 'Richmond Fellowship'. Some pre-existing 'retain' employment support offered as part of pilot pathfinder site and later through CCG funding. Employment support delivered from two co-located sites including one open plan arrangement.	Buckinghamshire CCG/County Council. Second least deprived county council in England. Population c.530,000. Rural/urban. Roughly equal numbers of referrals for out of work and in work clients.
Camden and Islington NHS Foundation Trust: iCope Camden Psychological Therapies.	Delivered through commissioned specialist employment/mental health support provider: 'Camden Work and Wellbeing by Hillside Clubhouse' Some pre-existing employment support offered as part of 2009 pilot. Service located in two co-located offices. One of these feels more integrated than the other due to open plan arrangements. However, clients are mainly seen off-site in community settings.	Camden CCG. Urban. Population c. 251,000. 60th most deprived local authority. EAs estimate that clients fall evenly across the three categories of out of work, in work but off sick and in work.
Homerton University Hospital NHS Foundation Trust 'Talk Changes'.	Embedded within NHS IAPT provider 'Talk Changes'. Provider has been delivering IAPT service for over ten years. Some pre-existing employment support offered with one EA already employed. All therapy and employment support offered from same site.	City and Hackney CCG. Urban. Population c. 286,000. 11th most deprived local authority in England. Even split between in work and out of work clients.
Dorset HealthCare University NHS Foundation Trust: 'Steps to Wellbeing'.	Embedded within NHS IAPT provider: 'Steps to Wellbeing'. No pre-existing internal employment support. Team divided between two office locations; one is co-located while the other not. Decision made by management team to start with a focus on job retention but has moved to include more clients who are out of work.	Dorset CCG. Population c. 766,000. Team split into East (comparatively urban with areas of deprivation) and West (rural and largely affluent). The balance between in and out of work clients is different across the rural versus urban areas: the former is more retain and the latter more regain.

East Riding of Yorkshire Humber Teaching NHS Foundation Trust: 'Emotional Wellbeing Service'.	Embedded within NHS IAPT provider: 'Emotional Wellbeing Service'. Part of 2009 pilot. Employment support delivered in co-located office and off-site in a range of community locations.	East Riding of Yorkshire CCG. Population c. 305,300. Rural/urban. Largely affluent but with areas of significant deprivation and high unemployment. Caseload supported at time of fieldwork estimated to be 80-90% employed and either in work or off sick.
Leicester City Nottinghamshire Healthcare NHS Foundation Trust: Let's Talk-Wellbeing service commissioned by Leicester City CCG.	Embedded within NHS IAPT provider Nottinghamshire Healthcare NHS Foundation Trust. No pre-existing internal employment support. Advisers meet with people primarily in fixed community locations during 'clinics' – there is a set rota for each EA taking different venues but on the same day each week.	Leicester City. Urban. Population c. 350,000 18th most deprived local authority in England. Higher than national average rates of unemployment, and benefit claimants. High youth unemployment. Caseload supported at time of fieldwork estimated to be equally split between employed and out of work.
Nottingham and Nottinghamshire: Insight Healthcare: Talking Therapies Services	Embedded within non-NHS IAPT provider: Insight Healthcare (a not-for-profit provider) commissioned by a group of CCGs in Nottingham and Nottinghamshire to deliver the Talking Therapies Services. Seconded staff from specialist provider 'Futures'. Employment support delivered in co-located office and off-site in a range of community locations.	Covers Mansfield and Ashfield, Newark and Sherwood, Nottingham North and East, Nottingham West and Rushcliffe CCGs. Rural/urban. Nottingham population c.329,200 14th most deprived local authority in England. Nottinghamshire population c.750,000. Nottingham city population is primarily made up of students, working people and families on lower incomes, unemployed and older people reliant on state support. The County has a mixed demography including areas with a highly-skilled working-age population and large pockets of deprivation with high unemployment. Caseload supported at time of fieldwork estimated to be equally split between employed and out of work.
St Helen's: Lancashire Care NHS Foundation Trust 'Minds Matter Talking Therapies'	Embedded within NHS IAPT provider Lancashire Healthcare NHS Foundation Trust. Commissioned by St Helen's CCG. No pre-existing internal employment support. Smallest service included with two staff at time of fieldwork with intention to recruit two further EAs. Co-located service.	St Helen's CCG. Urban population c.103,000. 36th most deprived local authority area in England, higher than national and regional unemployment. Referrals reported to be evenly split with roughly one-third in work; one-third in work but off sick and one-third out of work.

Where the service was contracted out, Clinical Leads were central to the design of the service specification. This role involved determining the size of the service, referral routes and caseload size; drawing up a tripartite agreement with WHU, CCG commissioners and the provider; and negotiation around costings and timings.

Where the employment support was delivered 'in-house', the majority of existing IAPT providers reported that they had been willing to take on the challenge of developing a new service or building on an existing offer and expressed enthusiasm at being able to lead and shape the service.

Where internal employment support expertise was lacking, the appointment of an experienced SEA and/or Service Manager to support service design, lead recruitment and provide early support to EAs was important. In one site, the Service Lead for the IAPT service identified the need to bring in external expertise from the beginning. A partnership was established with a skills and training provider, with staff seconded from the latter to provide the employment support component of the new EAs in IAPT service.

2.1.2 Staff recruitment

All sites except one experienced some level of challenge in recruiting staff with the appropriate mix of skills, knowledge, experience and *'necessary resilience'*[5] to deliver employment support within an IAPT context. With the exception of two sites, interviewees described the recruitment process as 'protracted', involving multiple (up to eight) rounds of advertising and interviewing before suitable candidates could be appointed. Numerous factors were identified as contributing to a difficult recruitment process, including:

- In NHS settings, the time taken to establish agreed banding and salary scales for new posts;
- In some sites the obligation to advertise internally before going externally;
- Uncertainty around where to advertise and the limits of advertising through the usual NHS routes; and
- Local employment markets which in some areas rendered the recruitment process *'tough…a big challenge,'* meaning they had to *'do things in different ways than we perhaps would have done before in terms of the interview process…we've had to massively go out and expand where we've advertised and the methods we've used to advertise'.* (SEA)

Where recruitment was experienced as a more straightforward process, the following two factors were felt to have facilitated the process:

- The ability to recruit internally from a pool of qualified employment support workers; and

[5] A resilient employee can be defined as someone who is less affected by workplace stress and its associated negative outcomes. Employee resilience training is offered to staff within a range of organisations including some of the EAs in IAPT providers.

- Availability of suitably experienced people in urban areas where a number of other employment support programmes were ending.

One site experienced early challenges with retaining staff, with several EAs leaving their posts shortly after being appointed. A number of reasons were given for this including: recruits viewing the role as a 'stepping stone' into a therapy role; different styles of management across different sites with staff in one area feeling they were being led by two managers with different approaches; and the absence of the promised national training programme (described in more detail below).

Several sites recruited either a Service Manager and/or at least one SEA before rolling out recruitment to EAs. Where time was sufficient, this gave Service Managers and SEAs the opportunity to design elements of the service and manage the whole process of recruitment, including organising training and induction before bringing in the wider team. This was identified as an important facilitator of smooth service set up. In other sites however, recruitment of SEAs came either only shortly before or was concurrent with EAs appointments. Here, early implementation felt hurried, and SEAs reported having to learn systems and processes alongside EAs and taking on the early face-to-face work with clients. In these sites, SEAs felt they should have been appointed earlier to facilitate early implementation and ensure appropriate staff were appointed:

> *'If the two seniors would have been employed before the Employment Advisers, it would have been better. I was employed at the same time as [names of EAs] …as a senior, you don't want to be going "God I don't know this computer system" …'* (SEA)

> *'If you try and rush something like that when you're a whole new team…some people come from different backgrounds, you'd need to think about their training, their experience, induction period, gelling as a team, what are our service values, what are our aims, what are our objectives. It would have been nice to have some time to devote to those things, to gel and build.'* (SEA)

All SEA appointees had experience of working in employment support and with vulnerable people, although some had considerably more experience than others. For example, one interviewee had fifteen years' experience of employment support and had managed an Individual Placement and Support (IPS) service while another had relatively limited employment support experience but had worked within a range of settings with vulnerable adults.

EAs came from diverse backgrounds, with experience that varied widely both between and within local programmes. Only two sites had succeeded in recruiting all their EAs with a background in delivering employment support to vulnerable people: one that was able to recruit from local employability providers and the other who had an internal resource to draw upon. These two exceptions aside, programmes had appointed teams with a range of experience. This included administrative work within an IAPT or other mental health setting, advocacy, counselling, HR, supported housing, employment support and JCP-related roles.

Despite the challenges experienced in recruitment, all local programmes were confident that they had managed to recruit teams who were motivated and with the requisite range of skills and experience to deliver a good quality service.

2.1.3 Staff training and support

To support the delivery of the EAs in IAPT programme at the local level, funding had been allocated nationally for a specially commissioned 8-week accredited training programme for both EAs and therapists. Delays in procurement, however, meant that Wave 1 went live without the intended national training offer in place.

Many EAs interviewed across the case study sites reported that one of the attractions of the EA posts was the promised national training programme, and the opportunity it offered in terms of career progression. Some EAs expressed disappointment when they heard that the training had been put back indefinitely[6]:

> *'The possibility of putting something extra on all our CVs, getting two years' worth of experience in something that we've never done before, and then it's come to it and we're nearly a year in and nothing ...'* (EA)

Given the relative lack of employment support experience among new EA teams in some sites, the national training opportunity was also described as very important for upskilling new post holders and complementing the in-house support that SEAs could provide:

> *'Being an Employment Adviser in an IAPT service is very different to being an Employment Adviser outside of an IAPT service, because you have to understand all the complexities and stuff that comes with the IAPT team. So, we were really excited about having that. We can send these new Employment Advisers, who we struggled to recruit with previous experience, on this brilliant new national training and it will really complement the bits that we don't have… it was a really big disappointment that it's just never materialised'.* (SEA)

Some EAs who lacked previous experience of delivering employment support described feeling nervous when they first came into post: '*I think we're all just absolutely petrified, giving someone wrong advice'.* These staff had had to learn quickly and 'on-the-job', spending a considerable amount of time researching the answers to presenting problems. In some cases, this took longer than doing direct work with clients:

> *'No one client is the same. Everyone is different, so it means you're having to research it. You might only spend half an hour with them on the phone but then you've got two- or three-hours' worth of research'.* (EA)

Even where staff had experience of employment support this was often in the context of working with people who were out of work and not those who were in work experiencing difficulties. As such, employment law, mediation and working with

[6] The national training programme is now being rolled out.

employers were commonly identified as gaps in EA knowledge. EAs in some sites also identified training needs in relation to mental health issues and treatments, such as suicide prevention and how to have conversations with clients about suicidal thoughts. In a minority of cases, these training needs had been met via access to in-house courses and input from therapists, but in most cases, interviewees felt they would benefit from further training:

> *'For me it's more when I come across somebody with a mental health condition and I have no idea how to react or interact, or if, am I going to push boundaries by challenging you, because I don't know. And it's that lack of knowledge with regard to these different medical conditions…if there was some sort of training, I think that would help me'*. (EA)

All local programmes had responded to the lack of a national training programme by developing a package of both training and on-going support for EAs. In some areas, SEAs and Programme Leads reported that they had invested a considerable amount of time in the first year of implementation in designing and delivering programmes of in-house training for EAs. Training packages differed across local areas, with some offering a wide range of themes and modules while others were more light touch. Training typically included elements of the following:

- A general induction covering issues such as safeguarding, first aid, data protection and working within the NHS;
- Introduction to the IAPT service, how it works and what support is available to clients;
- Detailed information on the role of an EA including:
    - how to structure a support session and develop a support plan;
    - the types of questions and problems clients present with;
    - sources of support and information to help answer those questions;
    - how to signpost effectively; and how to support a client to appropriately exit the service;
- Supporting employed people with job retention including ACAS[7] training, mediation and employment law;
- Supporting out-of-work people including CV writing, job searching, and benefits advice – in some sites delivered in partnership with JCP staff;
- Use of the IAPTUS, PCMIS and other NHS data systems[8]; and
- Resilience training.

[7] Advisory, Conciliation and Arbitration Service.
[8] IAPTUS and PCMIS are case management software systems for clients receiving psychological therapies

Some areas had also included training for therapists, such as on the role of the EAs and when and how to make referrals, and the importance of employment for mental health.

As well as organising in-house training, SEAs worked in a number of ways to provide supervisory support and advice to EAs. Examples from across case studies included:

- Opportunities for structured observations of practice and shadowing experienced senior members of staff before taking on an active case load;
- Regular clinical supervision sessions with IAPT therapists;
- Day-to-day support and advice and guidance on issues as they arise; and
- Regular study / discussion groups, exploring real life case studies and discussing different ways of approaching them.

In addition to the support provided by SEAs, EAs identified a number of sources of information and guidance they had recourse to, including for example the ACAS website and the DHSC eXchange portal. They also described informal processes of support including peer support:

> '*We do sort of peer to peer support. I think it's quite good in terms of if we've got a question, if we've got case conferencing or just in a more informal process just asking people in the office how they've dealt with something, so yeah, that would be from, for me [name] or [name] but also from other EAs if they've experienced the same problem with one of their clients'.* (EA)

2.2 Delivery models

2.2.1 Designing the EA delivery model

The programme granted local services discretion over the EA delivery model. In the majority of areas, the job of working up the detail for the EAs in IAPT service was led by the SEA(s) and supported by Clinical and Service Leads. Where the service had been externally commissioned, interviewees described a collaborative process between the EA provider and the Trust or CCG, involving on-going discussion and, in one area, a series of joint workshops designed to map out client pathways. In two areas, where some form of EA offer was already in place, local programmes built on existing models, refining processes and addressing practicalities in delivery, meaning *'the model is not wildly different from what we used to do but offers a significantly broader range of support for clients.'*

The major area for development in all sites was to flesh out the details of the client journey from referral and assessment, through intervention, and exit. Developing policy frameworks, assessment tools, determining the scale and nature of support provided and data management were all key tasks.

Some programmes had experienced prolonged problems with IT set-up. In some areas EAs were still working with multiple platforms as NHS systems were not felt to adequately capture all relevant outcomes. Specifically, some areas felt they lacked data relating to their own key performance indicators (KPIs). Local programmes covering wide geographies had the additional challenge of identifying suitable community locations from where EAs could provide a service. Examples of locations used included libraries, community centres, cafes and clients' own homes. In these areas, access to NHS IT systems presented an on-going challenge as EAs were working out of non-NHS settings.

In discussing the national guidance provided to local programmes, interviewees expressed surprise that the guidance had not been more directive, and agreed that it had been *'…very, very brief and broad'*.

This was experienced as more of a problem in some areas than others. In three areas that had no history of employment support provision within the Trust, the relative lack of national direction was initially seen as challenging: *'the frustration really was lack of clear guidance'*, and interviewees described concerns over whether the service they were developing was in line with national expectations. In these areas, staff reflected that more guidance would have been appreciated, and that they felt unsupported in the early stages of implementation.

In others however, the brevity of the guidance was seen as less of a problem and was indeed welcomed as offering the opportunity for local ownership. However, it had meant that both providers and, in some cases, the commissioning NHS Trust/CCG, had had to do a lot of early work in developing policies and processes for their new services. This ranged from a few weeks to six months, and this was experienced as a significant length of time from an operational perspective:

> *'We did a lot of work around setting up what the model will look like, what our service operational policy will be, the practicalities of how we actually deliver the support and how we work with the NHS database systems'.* (Clinical Lead)

> *'I was quite surprised coming across, moving to a, something that's a national pilot and going right OK, so what paperwork do you want us to use? If we're doing an assessment, is there any national paperwork? And it was almost like we were told to look at the Centre for Mental Health website, look at some examples and choose what best fits.'* (SEA)

SEAs coming in to develop both new and existing services described an intense period of orientation and groundwork when first in post:

> *'My first week was getting to know how the [IAPT] service worked, learning all the abbreviations, what people did, the differences, how our referrals would work, where we'd be working because we don't see clients here, we work in the community…and then I think the second week I started working on the pathway, deciding the skeleton of how it was going to work… That was my first two weeks, and that was when I [was by] myself, there was a lot to take in'*. (SEA)

Given the amount of work that needed to be done, interviewees commented on how important it had been to recruit SEAs with the right experience and skill set to do this. In some areas, the timeframe for set-up was felt to have been too short, and where team members were recruited together this meant SEAs had to learn alongside EAs.

2.2.2 Referral, assessment and early engagement

Despite these challenges the freedom afforded to local programmes to develop their own approach was welcomed by providers, who felt that this not only offered flexibility but encouraged innovation in their own service and in other areas as well. Hence, different providers were reported to have evolved creative approaches to elements of their services.

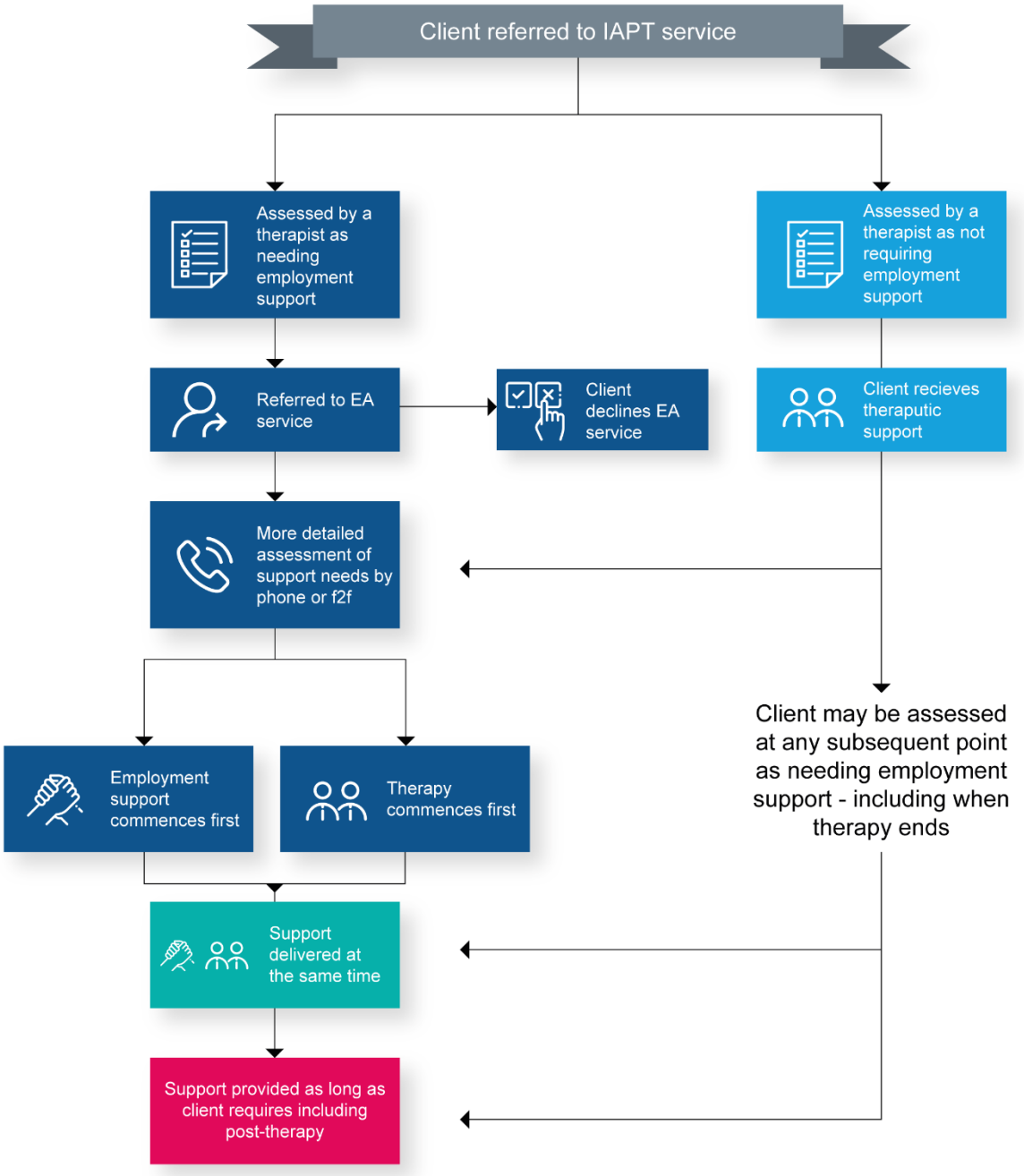
Figure 2.1 below provides an illustration of the possible pathways a client might follow from referral to the IAPT service and subsequently to an EA through to service exit.

In all local programmes, referral to an EA was made via therapists, commonly following an initial assessment process that included questions to determine whether or not the client would benefit from employment support. Clients could be referred at any point in their journey through IAPT if it later emerged that they would benefit from employment support as illustrated by these quotes:

> *'They can come to us when they've just had their assessment with [name of service], or it could be when they're actually working with a therapist or when they finish'.* (SEA)

> *'You've got somebody who comes in who doesn't think they want employment assistance, but all of a sudden, they're realising actually their job's the issue, so they'll move into creating the space to feel more confident and think, I'm worth more than this, I need more than this.'* (Therapist)

Figure 2.1 Referral pathways to employment support service



In one CCG, therapists described how they would refer most, if not all, clients to EAs as long as the client was not very distressed or in crisis. They explained how the majority of clients presented with problems that were related to their employment, and that even where employment was not an obvious issue, felt it was likely that most would benefit from at least an initial EA session.

In most cases, referrals were managed by a SEA, who typically reviewed the referral and allocated the client to an EA on the basis of capacity, geography and specialism (where these were factors). For example, if a client's situation required employer mediation and understanding of employment law, they would be referred to an EA

with particular expertise in this area. This approach differed slightly in two areas: in one site referrals were managed directly between the therapist and the EA, while in the other, the SEA would enter a referral into a database that was then accessed by the EAs, who would choose which client to contact and schedule appointments directly.

One site had revised their assessment procedures when it became evident that the original process was too time-consuming for therapists. The latter had been tasked with asking detailed questions about employment status and were sometimes not completely well-versed in what the EA service could offer. The revised process now involved a telephone assessment by an EA once the therapist had clarified with the client that they would like employment support. A second had operated an initial opt-in system whereby clients were required to fill out a form detailing their employment concerns, following which they were sent an information pack by the EAs. After a while it became evident that this was too onerous a process for clients. The revised process now involved a simple telephone assessment to see if they would benefit from employment support followed up by an appointment.

Waiting times for therapy services varied between local programmes. Where waiting times for therapy were longer, some sites offered employment support to clients before their first therapy session. This was a point of concern for some therapists who felt that EAs '*might be getting into conversations they shouldn't be'* and taking on a therapist-type role and for EAs who were worried about the consequences of not dealing adequately with clients' problems. Services were aware of these potential issues and were working to resolve them.

Other sites implemented a clinician-led policy whereby EAs would not start working with the client until the latter was receiving clinical support. In these cases, the EA would contact a client to let them know they had received the referral and informed them that they would be in touch once treatment begun. In most sites, EA support was available as soon as it was needed, and only one reported having a waiting list (which could be up to four weeks).

On referral, EAs would typically contact the client either by telephone or email and subsequently undertake a telephone or face-to-face assessment of their employment support needs. The length and intensity of support varied between local programmes. Hence, one site reported that clients were initially offered a block of six support sessions that could be reduced or increased as required. The issue of how and when to bring employment support to an end could be problematic for both therapists and EAs in some areas who were concerned to avoid encouraging dependency. This was one area where national guidance would have been appreciated.

All local programmes offered a mix of email, telephone and face-to-face support depending on client needs and preferences. EAs explained that some clients' needs could be met through fairly light touch support, commonly a phone call and follow-up emails if they simply wanted information or had a query. However, others needed longer-term face-to-face support, for example, where they were off sick because of workplace stress or were in work but experiencing relationship problems with a

manager or a grievance. In one site, EAs reported that initially the vast majority of their EA sessions were done over the phone, and that only clients with learning disabilities or social anxiety tended to receive the service face-to-face. This was an evolving picture, however, with a movement towards more face-to-face sessions at the request of the Clinical Lead as they believed this represented a better-quality service.

2.2.3 Capacity and the 1:8 ratio

The size of employment support teams varied across the case study areas depending on the geographical area covered, numbers of therapists, and the potential client base for the IAPT service. Larger teams employed up to ten EAs supported by two SEAs, meeting the national expected standard of one SEA for a maximum of six EAs. The smallest team employed just one EA and SEA but intended to recruit an additional two EAs in line with the increasing size of their therapy team and an associated expectation of larger caseloads.

In general, interviewees were confident that the 1:8 ratio had been achieved but, in some areas, this could be something of a moving target as clinical members of staff left or were recruited. Many interviewees were unclear as to the reasoning behind the 1:8 ratio and questioned the evidence base on which it rested. Nonetheless, there was the general feeling that it was *'about right'* but that services needed more time to become established before this could be tested.

Local services all established a preferred active caseload size ranging from 25 to 30. Most services experienced a slow start, with caseloads building from around 10 to the low to mid-20's at the time of fieldwork. In some sites, newer staff were still working with relatively small caseloads, although this was welcomed as it provided the opportunity to ease EAs into their role and build confidence. In general, it was felt that caseloads size was about right:

> *'It has worked quite well because if you give them a caseload that's too low, they have nothing to do, if you give them a caseload that's too high, they just become overwhelmed, so it's been quite nice to have a consistent number'.* (SEA)

Current caseloads also gave therapists confidence that clients would be contacted and offered support in a timely fashion.

Staff were concerned that as referrals increased the administrative burden could limit EA capacity. Estimates as to the number of clients who would benefit from the service varied across sites. In the absence of national targets for referrals some services had set their own based on experiential knowledge; for example, to engage a target of 10 or 20 per cent of the total number of new clients referred into the IAPT service. In another case study example, one interviewee estimated that the service was probably appropriate for up to one-third of their clients, and that this should be achieved over time. Some services also expected more time to be spent in direct face-to-face client contact, rather than by telephone or via email, thus increasing the intensity and time taken to support clients.

SEAs in some areas also carried active caseloads and discussed the challenges associated with their dual roles, including balancing increasing caseload responsibilities (which they enjoyed and felt it was important to maintain), with management duties. This improved as the management responsibilities associated with early implementation (for example, training new staff) decreased and EA knowledge and experience grew. Two services were developing new administrative 'employment advice support' roles to enable advisers to focus on the provision of support, rather than arranging appointments and more basic information recording.

2.2.4 Promoting referrals

Interviewees described a slow start to the referral process which they felt was primarily due to the need to build both trust in and understanding of the service amongst therapists.

> *'People weren't 100 per cent sure what this new thing was, how, what, which clients it could help, which ones, maybe, it wasn't so suitable for. So, I think it was just getting the clinician's head around actually, these guys can help a hell of a lot, and just making sure that it's in the forefront of everybody's mind'*. (Service Lead)

EAs felt that the positive feedback that therapists had received from clients was the most important factor in boosting referrals.

In addition, SEAs and EAs in some areas had spent a lot of time promoting their service to therapists, partners and the wider community. This had included active outreach to employers and Jobcentres, attendance at community events, the production of monthly newsletters, weekly updates for therapists, integrated EA and therapist meetings and in one area a 'referrer of the week' initiative.

> *'It's making a difference us spending time with the clinicians, letting them know what we can do, what we're about…We're really self-promoting…We've been going to a lot of events as well, in the community'* (EA)

In two areas, therapists explained that streamlining an initially complex referral process had made them more likely to refer a client to employment support, and that they had only referred those with more obvious needs before this.

The degree of integration of therapists with EAs was a critically important factor in ensuring referral, which is discussed in greater depth in Section 4 below.

3 Delivering the EAs in IAPT service in practice

This section explores the delivery of the EAs in IAPT service across the eight case study CCG areas.

3.1 Support for clients

All programmes provide both a “retain and regain” employment support service. In areas of greatest affluence, interviewees, perhaps not surprisingly, reported that the majority of their clients were in employment (often in well-paid professional jobs including teaching, medicine and law), with only a small minority being out of work. In the main, this reflected the client profile accessing the particular local IAPT service. However, in two areas there had been an initial decision to focus on job retention in the early stages of implementation, as these services were not yet ready to respond to clients who were out of work. Both these services were growing the range of support they could offer to out-of-work clients and increasing referrals from this group once a robust offer was in place. In one area, this involved the roll out of a series of workshops targeted at out of work clients that was in the process of development at the time of fieldwork. In the other, there had been the perception that partner employability services were better able to meet the needs of this group, although referrals of out of work clients were beginning to build.

In less affluent areas, the split was more even with interviewees commonly estimating that between 30 and 40 per cent of their clients were out of work with the remainder being either still in work or off sick and looking for a supported return to work. Some services were also working with a minority who were looking to change jobs but were not experiencing serious work-related problems.

3.1.1 For clients in work and struggling or absent on sick leave

Work stress and its impact on mood were described as common issues for people referred to the IAPT service. While the causes and particular detail of how work-related stress is experienced is specific to the individual, SEAs and EAs described a range of issues and problems that their ‘in work’ clients frequently seek help with. These clients often included people on extended sick leave or facing a disciplinary who ‘*do not know how to get back or whether they want to go back to work’*. Problems were perceived to be exacerbated by a lack of understanding of mental health issues in the workplace.

Common problems these clients present with include:

- Anxiety or depression caused or made worse by the nature of the job role or organisational restructures and change;
- Bullying, harassment, and challenging interpersonal relationships with managers and colleagues;
- A need for specialist equipment and/or reasonable adjustments;
- Individuals who have been issued with a disciplinary at work and want help to liaise with employers because union support is not available;
- People wanting to make a career change as they no longer enjoy or get satisfaction from their current employment;
- People with an improving mood, realising higher aspirations for employment but wanting support to achieve them;
- Challenging work-life balance with '*people spending a lot of time doing additional hours or it leaking into their personal life and affecting relationships outside of work'*;
- People who either want to take out a grievance or have had a grievance taken out against them;
- People who are on performance improvement plans but are *'not aware of what it's about or how it works or what will happen next'*; and
- People who have been referred to occupational health and '*don't understand, lack knowledge about their situation or have a very big fear of what's happening with that particular situation and what will happen next'.*

EAs offered a range of support in response to these presenting problems. EAs in most areas would typically co-design a bespoke support plan with each individual in line with their needs and preferences:

> '*It's very flexible depending on the client's needs because a lot of people actually work so they can't see us so a telephone call during their lunch hour might work better for them. So, we would just give them practical information, advice, guidance throughout the six months if they need it. Some people only need a month, three weeks, it just depends on what their needs are, and then we close them, hopefully, with a good outcome'.* (EA)

Supporting clients who are in work but off sick involved helping them to: 1) review their work situation and identify the issues that were either causing or exacerbating their mental health difficulties; and 2) either support a return to their current job or a move towards alternative employment.

Strategies for supporting a return to work commonly included:

- Management of a staged return, including EA attending return to work meetings with the client;

- Liaising with employers to arrange reasonable adjustments or (with client consent) engaging with any internal performance management actions (e.g. disciplinaries);
- Generally acting as mediator or advocate between client and employer;
- Developing a Wellness Action Plan (WAP) or Wellness Recovery in Employment Action Plan (WRAP)[9]; and
- Advising on employment rights.

Where clients preferred to change jobs, EAs would typically offer practical support, for example with job search, CV and letter writing, preparing job applications and interview skills. In some cases, EAs had also supported clients to access new training opportunities. In the majority of programmes offering a more open-ended EA service, support could continue after therapy had finished. This time was often used to support people to prepare for interviews or go through application processes.

One local programme was also planning to offer the opportunity to attend 'Work Well' group sessions to their in work clients, covering issues such as assertiveness, workload and work-life balance.

3.1.2 For clients out of work

EAs reported working with a mix of short- and long-term out of work clients. In larger more rural areas, these clients tended to be concentrated in specific areas, and EAs would often deliver support sessions in community settings. Supporting long-term out of work clients in isolated areas of high unemployment, where public transport links were poor, was described as particularly challenging. For these individuals, support would typically focus on increasing motivation and confidence to apply and maintain employment, rather than simply increasing job skills. There were also examples of people who had retired and were looking for renewed purpose, as well as older people close to retirement who had been made redundant and were struggling with change and perceived ageism from employers.

After an initial process of identifying clients' priorities and areas of focus, EAs would typically work to support them in the following ways:

- Helping clients who were long-term out of work to understand the mental health benefits of work, sometimes through taking up voluntary work first;
- Enabling people to access courses and retraining opportunities;
- Working on confidence, self-esteem and building aspirations;
- Developing and practising interview skills;
- Creating 'backward career paths' to identify small steps to help them achieve their ultimate employment aspirations;

[9] A WRAP is an evidence-based action plan to help employees manage their mental health at work. Managers work with employees to develop a personal action plan in advance for times when they are coping less well.

- Help with CV creation, personal statements, job searching and application completion;
- Sorting out basic requirements to apply for employment (e.g. opening a bank account, getting ID);
- Accompanying clients to recruitment agencies and JCP; and
- Signposting to other agencies including local organisations that offer training and volunteering opportunities, Citizens Advice Bureau (CAB), and other local third sector organisations.

One local programme had already developed and run group sessions for out of work clients. Delivered over six weeks, these sessions covered a range of issues including practical support to prepare for employment, time management, confidence building and an exploration of the barriers to and benefits of, work. A second site reported that they were planning to run a similar programme in the near future.

3.1.3 Key Challenges

EAs and SEAs identified a number of challenges in delivering employment support to clients within an IAPT context. A common concern was with supporting clients who have been referred into the EA service before they have begun their therapeutic intervention and before they are ready to deal with their employment issues. While interviewees stressed the importance of early intervention and prevention, they also explained that *'Sometimes it can be really challenging to support someone with their employment issue when actually if they were able to have their therapy treatment, they'd be in a better position to work on their employment situation'*. Moreover, if clients are seen before clinical decisions are made, it can mean that an employment appointment occurs before it is decided that the client is not an appropriate IAPT referral. However, some EAs felt that this could also work the other way, as *'sometimes it's of benefit for them to have employment support before they have therapy, because a lot of their anxiety or their depression can be resolved by dealing with that particular employment issue'*.

Interviewees also noted the challenge created by a lack of central guidance on how and when to bring employment support to an end. Where programmes had left this open-ended, interviewees identified two problems. First, they raised concerns about clients trying to engage EAs 'as therapists' following discharge, with some of their mental health issues unresolved. In these situations, employment advice sessions could become focused on issues better handled by therapists *'you're the one that's left working with that client on those issues but really you shouldn't be'* (SEA). In some areas, referral back to the IAPT service was an option, although there could be a waiting list for this. In others, EAs described a *'very challenging'* situation, often feeling ill-equipped to deal with problems such as anxiety and depression and explained that these could act as barriers to them moving their clients forward with employment-related issues. Second, EAs and SEAs identified challenges with the need to balance support with creating a sense of dependency: *'we do need to be*

empowering people to do things on their own' (SEA). Establishing clear goals and an exit plan for clients were important in helping to achieve this.

In some areas, a form of clinical supervision or support had been made available to EAs to mitigate these challenges. This generally took the form of one-to-one support and advice and/or regular case reviews or discussion groups, to give EAs the opportunity to think about difficult conversations and how they might deal with them.

3.1.4 Integration of employment support with IAPT

In all eight CCG areas, employment support staff had worked hard to ensure the integration of their service with IAPT teams. It was clear that the most important factor supporting integration was co-location of EAs and therapists. This was best evidenced in those areas where teams were split across locations, with some EAs sharing office space with therapy teams and others sitting alone. Where EAs sat in isolation they reported a range of problems, including securing referrals and chasing up missed appointments. Four of the eight case studies had multiple office arrangements, and all agreed that integration between EAs and therapists worked best where teams were co-located.

Co-location was widely described as enabling trusting relationships to form between therapists and EAs by facilitating opportunities for informal, personal communication and information sharing, resulting in closer and more effective working. Allowing therapeutic teams to see first-hand the work EAs were doing gave them greater understanding of their work, and the visible presence of the employment team within the service meant therapists were more likely to make referrals. Where teams were split across sites, interviewees noted that therapists were more hesitant to make referrals, and that therapy teams had taken longer to understand the role of the EAs and often 'forgot' that support was available:

> *'So one of the locations I work with, we've actually got two of the EAs who are based there, and that just works fantastically then because we can just go in and offer an informal chat before that referral is made and equally, between sessions, it keeps us all on the same page, so I think that kind of help does generally work better overall, but if it's somebody in a different location or EA in a different location, it just tends to, then, go through admin and you don't get much contact, really, unfortunately'.* (SEA)

Where therapists and EAs were co-located it was easier for them to stay in close communication when working with the same client and discuss joint, holistic approaches to solving problems:

> *'So, for example, if we feel that a client might be having a specific issue, it might be that they've got some anxiety about getting on a bus, then we would ask the therapist to look at coping strategies in one of their sessions. We would feed that back to the therapist, we need to work on this so that we can overcome that obstacle, get this person physically on a bus to work. So, we work quite closely with them, we have good relationships.'* (EA)

Co-location also made it much easier for clients to see both their therapist and their EA on the same day. This reduced practical barriers like travelling time and expense, but also the emotional barrier of having to travel to an unfamiliar place to see an EA for the first time. Interviewees gave examples of therapists guiding their clients to the EA's office after their therapy session, when clients had failed to get in touch with the EA despite being referred and contacted.

Despite the benefits of co-location, EAs emphasised the importance of continued efforts to build and maintain relationships and raise the profile of the EA service. Therapists were often described as extremely busy, meaning they could sometimes forget to refer. A high turnover of therapists in some areas also meant it was important to maintain a high profile for the employment support service:

> *'We've always been a smaller team than therapists and it's quite easy to get overlooked if you are such a small team and with the therapists, they are super busy in what they're doing so it's like, well, yeah I'll do my bit and it's OK, so I think referrals have always been a difficult thing, but you have to be visually there'.* (EA)

Both EAs and SEAs had worked hard to be visible and foster good relationships with therapy teams and described a range of strategies they had developed to promote referrals and to establish good channels of communication and joint working. These included a combination of: attendance of an EA or SEA at IAPT monthly meetings; joint team meetings; case conferencing; monthly 'clinics' during which therapists could ask EAs questions; staff wellbeing events like team building lunches, and in one area, raising the visual profile of the EA team by decorating desks with red balloons. One team had established a 'referrer of the month' scheme which, they reported, had been highly successful in increasing referrals. EAs working from relatively isolated community locations had to work particularly hard to ensure they maintained their profile with therapists.

3.1.5 Working with employers and employability partners

One of the broader strategic objectives of the national EAs in IAPT programme is to help break down barriers to integrated working between employment and mental health services. At the local level, the development of collaborative relationships between EAs in IAPT providers and local employers, trade unions, JCP and other organisations within the local labour market is intended to help achieve this.

Across all case study areas, links had been made with a range of employability partners, and all programmes had focused on proactively building networks with relevant organisations including JCP, local authorities and third sector providers. Teams had also made links with services to whom they could signpost clients, including for example, CAB, National Careers Advice, local colleges and other training providers.

At the delivery level, SEAs and EAs worked closely with local employment support agencies, and in some areas were part of local workability groups providing opportunities for networking and increased mutual understanding of members'

service offers and roles. Where EAs had previous employment support experience, they drew on their established networks both to promote signposting into their service and to identify volunteering and training opportunities for their clients. For example, in one area where the employment support service had been commissioned from an external specialist provider, EAs had been seconded into the new service and benefited from having had the right contacts and experience to draw on to provide a high quality signposting service to their clients from the outset.

EAs and SEAs most commonly reported close working with local Jobcentres to help facilitate joint approaches to supporting clients and signposting in both directions. In some areas, EAs also spent regular allocated time working out of local Jobcentre Plus. In three programmes, EAs and SEAs had run workshops or given presentations to Jobcentre work coaches to provide an overview of their services and widen understanding of the sorts of barriers and challenges to work that people with a mental health problem might face.

EAs were commonly working with individual employers to help facilitate a return to work for clients. Other EAs, particularly those helping clients who are looking for work, had also taken time in some areas to proactively approach local employers to seek out suitable employment opportunities that they could suggest to clients. This was easier where EAs already had established networks to draw on.

On a more strategic level there were few examples of proactive engagement with employers. In one local programme, however, the employment team had been contracted to work with employers, primarily through the delivery of a series of workshops designed to promote awareness on mental health within the workplace. Four workshops had been planned and were due to be delivered shortly after fieldwork ended. These workshops aimed to increase knowledge and understanding of common mental health problems, examine how managers can support staff who disclose a mental health condition and explore how organisations can improve workplace culture to tackle the stigma surrounding mental health. This initiative built on earlier work the IAPT provider had developed with an EA site and was supported by existing collaborative relationships with employability partners.

Where this kind of structured work with employers had not yet been delivered or planned, EAs and SEAs expressed an aspiration to do so, especially where their experience with clients had highlighted the need for employers to better understand and support employees with common mental health problems.

Three EAs in IAPT services had developed more formalised strategic working relationships with a range of local partners. In two cases, these built on established strategic arrangements. In one, the CCG commissioner and EAs in IAPT provider were both members of a work and health steering group, brought together by the city council's public health and economic development departments. In another, discussions had been on-going between the Mental Health Trust, CCG, local authority and JCP around how an EAs in IAPT service might fit within the wider employability service landscape.

In the third CCG, a working group had been established to explore local mental health and employment needs and how these might be best met. The group has since met several times to consider national funding opportunities, establish client pathways through local services and develop a directory of local provision. In the third area, the district level JCP Partnership Manager was interested in advancing a preventative agenda and had been proactively involved in the IAPT service for some time. The manager had facilitated the development of joint workshops and active signposting between the IAPT service and local JCPs and was exploring ways to engage employers in becoming more mental health aware.

4 Case study findings: benefits and early outcomes

This section describes the perceived benefits and early outcomes resulting from the services in each CCG case study area.

4.1 Introduction

There was a high level of support for the EAs in IAPT initiative across all programmes and staff groups, including employability partners. All interviewees saw a need for the service and felt that the work of the EAs enhanced the existing IAPT provision. Therapists concurred that it was important for clients to have access to an employment specialist and that workplace stress or unemployment often underpinned or were a part of the problem that clients presented with. In the main, employability partners saw the EAs in IAPT service as filling gaps in provision, particularly for people who were in work. For those who were out of work, stakeholders felt that the service was more highly personalised than that which Jobcentre staff were sometimes able to provide.

Interviewees described benefits and outcomes at three levels: for partner organisations; for the IAPT service; and for clients.

4.2 Benefits for partner organisations

Filling gaps in provision: partner organisations reported that EAs in IAPT services filled important gaps in provision that their own organisations were unable to close. Employability partners, including local third sector providers and JCP, were principally, and often exclusively, involved in supporting people into employment, leaving the needs of people in work unmet. Some of these worked with a client base that had been out of employment for a long time, often with mental health issues. Interviewees reported that it was common for these clients to encounter difficulties adjusting to the workplace environment, which could lead to them walking away from work rather than addressing problems as they arose. The EAs in IAPT service was experienced as a valuable resource, providing in work support to enable clients to get through these first difficult weeks and acting as a preventative intervention that stopped people from falling out of employment. Local JCP partners also appreciated the client-focused more informal and less pressured service that EAs could offer clients, contrasting it with organisations who had delivered other employment support initiatives:

> *'We have organisations that we work with and the people, it feels like they're going through the motions because they're getting paid for it, so you send me customers, I'm not bothered who I get, I can do this and this and, but, at the end of the day, they're just a number and they get paid for the number of people they see…. The support they're going to be given isn't fantastic, but it's just seen as a number and monies game, it doesn't feel right whereas this [EAs in IAPT] feels like the customer is the important thing in all of this and they can work at the customer's pace…they are desperately passionate about trying to do the best for their customers and move them forward.'*
> (Employability partner)

In a minority of areas where mental health charities were able to offer local employment support, waiting lists were reportedly long for these services.

Providing additional support in dealing with mental health issues: Several local programmes had established arrangements with JCP offices whereby S/EAs spent time supporting work coaches and/or running workshops on mental health in employment issues. In some areas, EAs also offered valuable additional support to JCP clients including, for example, workshops on anxiety and drop-in employment advice sessions.

4.3 Benefits and outcomes for IAPT services

Therapist time is more focused on therapy and clinical support: Overall, therapists were very positive about the addition of EAs to their teams; and reported that therapy time could now be more effectively focused on issues such as feelings, thought patterns and coping techniques in the knowledge that practical problems relating to employment were being dealt with separately by the EAs. Although workloads had remained the same, they felt they were achieving more through their sessions:

> *'If somebody's coming to the service and employment's an issue, it's the main issue. So, if you can work on that, by the time they get to treatment it should be easier for the therapist to work with because the employment's been dealt with.*' (Service Manager).

> *'Because they aren't limited in terms of time, and obviously they've got the expertise to signpost into the communities, it takes that away from me and then I can focus on things like low mood and anxiety rather than stuff that I shouldn't really have to.'* (Therapist)

Therapists time spent more efficiently and waiting times reduced: Two local programmes reported that because clients could access support from an EA on referral to the IAPT service, it was their view that overall waiting time to receive treatment through the service was decreased and clients were not being left unsupported for an extended period of time. It should be noted however that this was reported by interviewees and needs corroboration with service data when

available. This was particularly useful where the cause of the clients' stress or anxiety was rooted in employment. It was reported that a small number of clients receiving EA support had opted not to see a therapist, while others had needed fewer therapeutic sessions[10]. This was identified as a positive outcome, as it meant therapists' time could be more efficiently used supporting individuals that need their specific expertise.

Reducing burn-out: In one local programme, the Clinical Lead reported that the EAs had brought wider benefits for the IAPT teams:

> *'The introduction of the employment team has had a bonding effect…they are great at team dynamics… and this has helped addressing issues of flow among the low intensity practitioners…there is a lot of work stress and 'burn out' associated with IAPT.'* (Therapist)

In a second area, a therapist reported that the positive personalities of the EAs has brought a *'breath of fresh air'* and an additional energy to the service.

'One-stop-shop' provision: In all sites, interviewees described the positive impact of provision being available 'in-house', even where this was provided off-site, contrasting this with earlier efforts to support clients experiencing employment crises:

> *'Before they were signposting to all these different agencies, now clients have their therapist, and they have their Employment Adviser who will try and help them with other things too. I wanted it to be, not be a signposting service because then anyone can do that. So, if somebody has benefit problems, the EAs will ring them, ring the Jobcentre with the client, so it's like one less thing that they're having to go to somebody else for, I think that's the best thing about being here, the fact that we are here, and they're not just being sent to another organisation.'* (Service Lead)

One therapist explained that where previously clients might have been referred or signposted to an external organisation, it wasn't always clear whether they had been seen or if any action had been taken. With the employment support provided in-house, therapists were in immediate contact with S/EAs and able to resolve issues without undue delay:

> "*Now I will ring [the SEA], I've rung [the SEA] a few times [when I'm doing an assessment] to say, I'm just with somebody and they've just lost the job, what should I do and he's either given me some advice or I've asked him to give them a ring, and it's just solved it there and then. Rather than a like, oh well I'm just going to refer you there, and you go to another wait, we've just done it."* (Therapist)

[10] As above this would need triangulating with service data when available.

4.4 Benefits and outcomes for clients

Benefits and outcomes were described for each of the three target groups for the EA in IAPT service: clients in work but struggling; clients in work but off sick; and clients who are out of work.

4.4.1 Helping clients in work to manage their condition and remain well

While there were variations across local programmes, a considerable proportion of clients seeking help from EAs in IAPT services were reported to be in work but struggling with workplace stress. Common strategies to support these clients included mediating between clients and employers, advising on employment rights and building confidence and self-esteem. EAs would typically co-produce a 'wellness action plan' with clients as a basis for negotiating reasonable adjustments with employers. Reported benefits for clients receiving EA support included:

- Helping to identify sources of workplace stress or anxiety;
- Helping to identify and negotiate reasonable adjustments;
- Setting goals and strategies for returning to work and;
- Supporting people through workplace processes including disciplinaries.

Commonly reported outcomes for this group of clients included:

- Successful negotiation of reasonable adjustments;
- Client supported into new employment;
- Reduced anxiety and stress;
- Improved well-being;
- Increased confidence, assertiveness and motivation

The following case studies provide examples of how clients have been supported by EAs to improve their workplace situation and stay in work. All names have been changed to preserve anonymity.

Case study 1 Rebecca: reasonable adjustments
On referral, Rebecca had recently been diagnosed with multiple sclerosis and was suffering from a low mood. In particular, she was struggling with aspects of her job: the temperature of the office and, when her symptoms worsened, the journey to work. The SEA worked with her on how to raise these issues with her employer, informed her of her rights to reasonable adjustments and built her confidence to have the right conversations. As a result, her employer agreed to provide her with an individual heater and allow her to work more flexible hours. This significantly improved her sense of wellbeing and ability to stay in her employment.

Case Study 2 Ana: challenging poor management
On referral to the EA in IAPT service, Ana was suffering from chronic gastrointestinal problems which were exacerbated by stress. She was being bullied by her manager about her condition which was making it worse, with the result that she missed work more frequently. Her manager had tried to make her accept a zero hours' contract,

leaving Ana very anxious. The IAPT therapist and EA worked in tandem to support Ana: the therapist on assertiveness and anxiety, while the EA attended employment meetings and helped her to take out a grievance procedure against the manager, who was then investigated when others made similar complaints. The EA also helped Ana to set down what her needs were and present these to her employer. These were quite simple things and included toilet breaks and being located near to the toilets. These changes were successfully negotiated and, following the grievance procedure, Ana remained on a permanent contract.

4.4.2 Helping clients on sickness absence to make a successful return to work

Interviewees described supporting people signed off from work for long periods, sometimes with physical health conditions, and presenting with poor mental wellbeing, stress and anxiety. Reported benefits for clients receiving EA support included:

- Helping to identify the source of workplace stress or anxiety that had led to sick-leave;
- Setting goals and strategies for returning to work and;
- Supporting people through workplace processes including disciplinaries.

Commonly reported outcomes for this group of clients included:

- Successful negotiation of reasonable adjustments;
- A return to work;
- Client supported into new employment;
- Reduced anxiety and stress;
- Improved well-being;
- Increased confidence, assertiveness and motivation.

Case Study 3 Kate: reasonable adjustments

Kate is a teaching assistant who was referred to the IAPT service with anxiety. While she enjoyed her job, she was finding work challenging, especially as her colleagues were unaware of her anxiety and the impact this was having on her life. Off sick from work, Kate was referred to an EA who helped her to unpick exactly what it was at work that was making her feel anxious. It transpired that the key problem for Kate was the social isolation that she felt at work, not helped by a hot desking arrangement and a lack of positive feedback on her contribution. The EA worked with Kate to agree a WRAP[11] and supported her to return to work through negotiating some simple measures with the school to facilitate this process. The EA also helped arrange a meeting between Kate and her line manager, which the EA attended as added support. Following this meeting, the school arranged a buddy for Kate, another teaching assistant who would take her to lunch and generally help her to reduce her feelings of isolation.

[11] Wellness Recovery in Employment Action Plan.

> *'I feel that was a real positive outcome because, A) she was back at work, B) she was a lot happier in herself and she was continuing to work with the therapist when I'd finished so I'm hoping the anxiety was resolved in time and she felt better in herself'*. [EA]

For some people, the optimum solution was to resign from an exceptionally stressful work situation and secure alternative employment, as in Keith's case below:

Case study 4 Keith: seeking a better employment situation
Keith had previously been hospitalised with dizziness and falling, symptoms that were subsequently established as stress-related. His work situation was the main source of this stress, compounded by a series of challenging personal life events. These circumstances had prompted him to take a job in a call centre, where he had worked for over a year. Keith reported that the workplace conditions were extremely difficult, with employees being expected to work nine hour shifts without taking a break. Both employees and managers were regularly in tears at their desks. At the time of his first SEA appointment, Keith was intending to resign following a period off-sick and was reticent to meet the SEA in a public space for fear of running into people from work. The SEA at first tried to discourage him from resigning, suggesting that they work to secure employment rights in this situation. However, Keith was determined to resign and left his job. The SEA described this as a good outcome given the circumstances and was helping Keith to secure alternative employment which she was confident he would achieve.

4.4.3 Supporting out of work clients to return to work

For clients that were out of work, therapists and EAs reported that several had been supported to find work successfully, while many had been invited to interview for the first time in many years. Clients who had retired, and found retirement detrimental to their mental health, had also been helped to find employment. Along with practical support promoting self-esteem and confidence, giving people a sense of hope was described as key. Even where clients had not secured employment there had been positive impacts on their mental health.

Commonly reported benefits and outcomes for this group of clients included:

- Increased confidence, assertiveness, and motivation;
- Improved mental health and wellbeing;
- Entry onto training course; and
- Progress into and towards work

The following case studies provide illustrative examples of people who had been helped either into or towards employment.

Case study 5 Jason: steps towards employment
Jason is in his 20s and has Asperger's Syndrome and mental health issues. On referral he lacked a daytime routine, commonly sleeping all day, and staying up at night playing computer games. As someone who was not yet ready for employment, his EA supported him to access a media project initially once and then twice a week,

to help build a daytime routine. Jason had been assigned a support worker by social services who had recently told the EA that he had given a presentation in front of 300 people and was being considered for a job at a local supermarket.

Case study 6 Eli: spending time to build confidence

Eli is a 30-year-old man with Multiple Sclerosis (MS) who had had a recent, severe relapse on referral to IAPT. As a result, he now has to walk using an aid and has co-ordination difficulties. He used to work full time but has been out of work since his relapse. He was concerned that he would be discriminated against, and his confidence was very low.

His therapist reported that he was much happier once he began meeting with an EA. The EA had encouraged him to think about working from home as a realistic option but also given him very practical help, providing a supportive presence while he walked down the street to ameliorate fears that he was being stared at. Prior to this, Eli had been taking taxis because he was embarrassed about the way he walked, and this had severely curtailed his freedom. The time spent by the EA in helping him to walk, something the therapist would never have been able to do, had hugely improved Eli's confidence. He now walks more often and feels much better about himself. He does not have a job yet, but his anxiety and depression has improved.

Case study 7 Steve: returning to work

Steve was referred to IAPT because he was depressed about not being able to work. He had previously been extremely anxious, which was worsened because he worked in a call centre which was open plan - the pressure of being there, taking calls with no breaks led to a panic attack and he quit his job. The initial therapy work was around the low mood, so it was agreed he would increase his level of physical activity before focusing on anxiety levels once there was progress on this – at which point he wanted to return to work. Following a referral to the employment service he was invited to multiple interviews in a very short space of time and secured a job by the end of therapy. He had a sense of purpose and was happy to finish therapy.

Case study 8 Jack: building aspirations

Jack presented to the IAPT service with depression following a long period of unemployment. He had left his last cleaning job due to bullying and was struggling to find alternative similar work. During a series of sessions with an EA he was supported to identify other skills and encouraged to look for better paying work. With EA support, he successfully applied for and secured employment as a tram driver. He is now earning more money, and his mental wellbeing has much improved.

Case Study 9 Bob: returning to work after being long-term out of work

Bob had a history of Post-Traumatic Stress Disorder and had not worked for several years. He had been seeing a therapist for some time before he decided that he was ready to consider a return to work. The EA and Bob worked together to build his confidence and put together his first ever CV. From here, the EA helped Bob to apply for jobs and go for an interview. Bob is now working full time for the first time in many years. Here the EA describes why the integration of employment advice with therapy was important:

'*We were able to work together…you break down the barriers and then slowly but surely you gain the confidence and inner skills and we got him his first ever CV that he'd ever had, and first ever interview that he'd ever had. Yeah, so he's got a full-time job now, he's completed all his therapy sessions, he's completed everything with us now. I think for me it epitomised exactly why the Employment Adviser service should be coupled with the emotional wellbeing service. It was the full procedure from start to finish. He'd been to see the therapist; the therapist had got him to a point where he could consider changing his lifestyle and getting back to employment. And then we, and I was able to get involved obviously and help and support and get him back to employment'* (EA)

5 Conclusions and recommendations

This section provides our conclusions, with recommendations for consideration for the rollout of Wave 2 of the programme.

5.1 Conclusions

The evidence from interviewees in the local programmes suggests that the EAs in IAPT programme has been well received by clients, therapists and Clinical Leads and fills important gaps in employment support for people experiencing common mental health problems. The programme has increased capacity to deliver employment support to people accessing IAPT services. While not always clear about the rationale for the 1:8 ratio, local providers reported that they thought it had been achieved and feels 'about right' in terms of their ability to meet current demands on the service.

Local programmes experienced early challenges in recruiting EAs with the right mix of skills and experience. The scale of the challenge varied and ease of recruitment was in part contingent upon both local employment markets and whether the service had been commissioned from a specialist provider or NHS Trust. Where Trusts were building a new in-house service in areas of relatively high employment, and/or where they were mandated to advertise internally first, recruitment was particularly difficult. Despite challenges, programmes were confident that they had recruited competent staff teams. Factors promoting ease and quality of recruitment included: the ability to second staff from a specialist provider, other employment initiatives coming to an end, and working in partnership with local authorities who could assist with recruitment. Early appointment of experienced SEAs emerged as critical to the success of local programmes. This enabled them to take ownership of staff recruitment and ensure processes and protocols were in place before active caseloads became established.

At the time, the absence of the national training programme[12] was sorely felt by some local programmes, particularly those who had recruited relatively inexperienced EAs. Here EAs reported 'learning on the job', often spending longer researching online for information than working face-to-face with clients. Inexperienced EAs also reported feeling stressed and nervous in the first few weeks of taking up their new role but described feeling far more confident at time of fieldwork. In response, SEAs and Service Leads had established their own programmes of training and strategies for giving on-going support. This was best managed where SEAs had been appointed ahead of EAs. Gaps in knowledge most frequently reported and where training should be offered include employment law, and knowledge and understanding of common mental health problems.

[12] The national training programme has now been developed and rolled out since March 2019.

National guidance on how to set up and implement EAs in IAPT services was described as 'brief', which was more problematic for some programmes than others. Suggestions for where best practice guidance would have helped most commonly included: recruitment; advice on commencing employment support prior to therapy (and when not to); length of support beyond the end of therapy; how to maintain professional boundaries; and general guidance on risk management. A central steer on the best use of IAPTUS and PCMIS was also requested. Some interviewees also felt that nationally developed materials such as assessment forms would have saved time and effort in programme set up. These aside, all programmes appreciated the flexibility that WHU had afforded them and felt that the ability to design services to fit the local context was key to success. Concern was expressed that scaling up might involve removing this flexibility, and that this should be avoided.

The EAs in IAPT delivery model was designed as an integrated service with the expectation that therapists and EAs would work collaboratively to deliver packages of complementary support to clients. The degree to which local programmes had achieved integration between EAs and therapists varied, but it was clear that co-location of EAs with therapists facilitated closest working. Informal contact afforded by shared office space enabled trust to build between therapists and EAs, promoting shared understanding of each other's roles and increasing referrals. Co-location also provided the optimum environment for delivering a dovetailed service to clients, allowing EAs and therapists to more easily plan joint responses to clients' needs.

The focus for all programmes in the first year of implementation has been on building referrals and delivering packages of bespoke support to clients based on their individual needs. All programmes were supporting a mix of people who are either in work but struggling; in work but off sick; or out of work. However, the makeup of caseloads varied between programmes, with some reporting an even split of in work and out of work clients, while others were largely delivering a 'retain' service. EAs combined face-to-face work with email and telephone support. Some Clinical Leads felt time spent working face-to-face with clients should be increased as this represented a better quality service. EAs were supporting clients in a variety of ways and work-based stress was often the root cause of or a compounding factor in a client's mental health problem. For those who were in work, support commonly included working collaboratively with therapists to build assertiveness and identify solutions to workplace challenges and stressors; advising clients of their employment rights; mediating between client and employer for reasonable adjustments; and supporting a staged return to work. For out of work clients, EAs commonly combined building self-esteem and confidence - importantly working in tandem with therapists - with practical support in looking for and securing employment.

The case study areas provide emerging evidence of the achievement of positive outcomes for IAPT services and clients. The additional capacity provided by EAs was widely recognised as having freed up clinicians' time to focus on the more directly therapeutic aspects of their role.

For clients, a combination of 'soft' affective and 'hard' employment outcomes were reported. Affective outcomes included: increased confidence and assertiveness;

better motivation and problem solving; and improved mental health and wellbeing. Employment outcomes for in work clients included improved working conditions following negotiation with employers; reduced workplace stress; a return to work for those off sick and securing alternative employment for those who no longer wished to remain in their former job. For out of work clients, outcomes in terms of both progress towards and in to work, were reported.

5.2 Recommendations for Wave 2 programmes

Our recommendations for the Wave 2 programmes, based on the Wave 1 case studies, are set out below.

Employ experienced SEAs prior to launch to lead recruitment and design of delivery models: A clear message from local programmes was the importance of employing experienced SEAs *before* EAs to give them the opportunity to shape staff recruitment, establish a programme of training and support for EAs and enable systems and protocols to be put in place before caseload responsibilities commenced. While not always possible, subsequent recruitment of EAs within a single timeframe enables training to be delivered in a structured and more economical way while ensuring that *'everyone starts on the same page'*. Set clear milestones and establish a timetable for setting up the service at the outset to ensure this is achieved.

Support integration of EAs with therapists: Interviewees stressed the importance of *'mutual bonding between EAs and the IAPT service'* and warned of the danger of siloed provision. Integration between EAs and therapists requires discussion across teams and the development of strategies for facilitating communication. Co-location represents the optimum arrangement for supporting integration, facilitating relationship building and informal communication between clinicians and EAs while enabling clients to receive support from a single location. Other strategies for supporting integration between EAs and therapists include integrated team meetings, joint training, and informal opportunities for team building. These are particularly important where EAs need to work away from main offices in community locations.

Employ staff with a range of experience and skills: Where possible, local programmes should aim to employ SEAs with experience of both employment support and working with clients with mental health problems. This is important as EAs might not always have experience of both and SEAs are key in providing guidance and support to EAs. Services should try to employ EAs with a range of mental health and employment support experience, including working with people in and out of work. This will facilitate peer learning and support and means that clients can be matched with EAs who can best meet their needs.

Think about the development and support of EAs: This is particularly important in areas where recruiting staff with experience of providing employment support to the IAPT client group is a challenge. Interviewees were confident that Wave 2 programmes would benefit from the roll out of the national training offer. However, it will also be important to consider EAs' on-going training and wider support needs and consider developing 'off the shelf' resources that they can utilise. Areas that might

need specific attention include: supporting people who are in work covering employment law and working with employers; and understanding and responding to common mental health problems (including how to deal with specific situations as they arise). As above, having experienced SEAs in post to support EAs is critical. For the Wave 2 areas, consider drawing directly upon the experiences of the Wave 1 sites as part of any support offer.

Consider developing 'off-the-shelf' resources for EAs: For example, a directory of local support agencies, a list of websites that EAs can refer to and a set of fact-sheets covering key issues such as employment rights.

Actively promote referrals: Even where good integration between EAs and therapists has been achieved, staff turnover and heavy workloads can work against referral. Maximising visibility, actively promoting the EA service and making the referral process as simple as possible all help increase referrals.

Consider the optimum local arrangements for client referral to and exit from EA support: Wave 1 programmes differed in terms of the point in the pathway when clients were referred to an EA and how long a client could receive EA support. Clients should repeatedly be asked if they require EA support at any point during treatment. In some programmes clients could be referred to an EA before therapy, and most clients could receive EA support once therapy sessions had finished. The experience of local teams suggests the need to establish clear, shared understandings of the limits of the EA role in working with clients who are not receiving therapeutic support to ensure boundaries do not become blurred and risks are appropriately managed

Set clear expectations for EAs in terms of activity and the way they should work: This includes factors such as the level and type of interaction expected; what should be handled face-to-face, when it is appropriate to deal with issues by phone or email and what could be delivered in a group session. As above, limits to the EA role should be made clear to prevent EAs *'slipping into a therapy role'.*

Establish collaborative partnerships between IAPT services and employability providers: This is important for two reasons: 1) to generate mutual awareness of each other's services, why they are important and what each has to offer and 2) to promote better understanding of the links between mental health and employment and to challenge stigma.

Appendix A.1 Topic Guides

Evaluation of EA in IAPT: SEAs, EAs and Therapists Topic Guide

This is the topic guide for use in the interviews with EAs, SEAs and therapists. The aim of the interviews is to inform preparations for Wave 2 by:

- Exploring implementers' perspectives on the rationale, design and delivery of the programme – in the context of the theory of change/logic model developed;
- Reviewing progress with early implementation of the programme; and
- Discussing experiences of the training and how this has supported practice.

Interviews will be semi-structured, undertaken face to face and will last around 40 -60 minutes. Interviews will be undertaken on the basis that participation and all quotes will be made anonymous; this will be made clear at the start of all interviews.

There will be a degree of variety in the interviews depending on the role of the interviewee in their CCG. This means that the topic guide is designed to provide a framework for discussions and not a question-by-question guide.

Before the interview:

- Ask for consent to record the interview. Explain that all interviews will be anonymised and no-one will be named in reports. Explain that they can ask for the recorder to be stopped at any time and that they can change their mind about taking part any time during or after the interview.
- Explain that the interview is confidential. The only time confidentiality won't be kept is if there is evidence of likely or actual harm to them or to another person.
- Stress that if there is anything that we ask that they don't want to answer, then they don't have to.

1.1 Introduction/Interviewee Background

Establish the interviewee's professional role and their role within the EA in IAPT programme: which organisation they work for, detail of their role, and the extent of their involvement in the EA in IAPT programme to date.

Explore their previous professional experience and their career progression into the role.

Collect data on:

- Previous ratio of EAs to therapist;
- Current/intended ratio of EAs to therapists; and
- Throughput of patients pre- and post-Trial.

1.2 Awareness and Understanding

How was the EA in IAPT programme introduced to them? – When, who and clarity.

Explore the interviewees understanding of the rationale for the programme.

- What is the programme trying to achieve?
- Why is it important – what problem is it trying to address?
- What are the key problems/barriers facing people with mental health issues with respect to employment?
- How do you feel the programme will help them overcome these?
- What might be the limits to the support the programme is able to offer?

1.3 Preparing for Implementation

Please describe the key steps in preparing for the programme in your area.

- What was helpful / enabled effective preparation and early implementation?
- Were any issues/challenges experienced? Describe, and if/how addressed.

Explore the experiences of interviewees attending the training programme:

- Can you briefly describe the training you have received through the programme?
- How has it develop your understanding of the clients' employment support needs?
- What worked well? What were the key things that facilitated the success of the training? Anything that hindered? What could have been improved?
- Has it impacted on your practice/interaction with patients? How?
- Has it helped you meet the employment support needs of patients? If so how?
- What further training (if any) would you find helpful?

1.4 Delivery Model

Establish the key steps in the delivery model – from the staff and client perspectives (in the context of the intended delivery model and the theory of change):

- Describe the EA in IAPT integrated service currently being offered to patients. Set out the key steps from referral/recruitment, engagement and diagnostic, service delivery and support, and completion/exit, as appropriate.
- Who are your key delivery partners – i.e. referral and employability partners? Describe their roles in the programme, and any previous collaborative work.
  - How well integrated do you think the therapeutic and EA elements of the service are? Explore referral mechanisms, communication between therapists and EA, integrated approaches.
  - What are the key factors that facilitate this?
  - What are the challenges?

- Who is the programme currently supporting? What types of issues and problems are you supporting people with?
- How does the model compare to that set out in the guidance? Is implementation as intended, or if any deviations, why and who does this affect? Any other implications?
- What are the key elements which help or hinder delivery? Why? Who does this affect?
- What have been the implications of moving towards the 1:8 ratio for staff and clients – what difference has it made? **Probe key issues and implications**, including:

  - Have, and to what extent, have the new EAs freed up therapist capacity?
  - Are the EAs currently working at capacity, or are they under-utilised?
  - Are there any capacity problems? Are the EAs over-tasked?
  - From the patient perspective, what will be the main differences they will have noticed? How long do they now have to wait to see an EA – compared to previously?
- How has performance (throughput and outcomes) compared to expectation? Probe for reasons of over/under-performance, and difference to pre-trial period.
- Overall, what is working well in terms of implementation/potential good practice? For who? Why?
- What is working less well regarding implementation and what could be changed? For who? Why?

1.5 Benefits and early outcomes

Explore any benefits for patients and outcomes more generally.

- How has the enhanced employment support offer benefited your patients so far? Explore differences for those in work, off sick and out of work.
- Are there any patients it has been difficult to support? If so who and why?
- What, if any, have been the early outcomes for patients?

Have you noticed any change in your clients'?

- Employment status – either finding work, returning to work, maintaining or securing new work;
- Views and attitudes to work;
- Efforts to find work/job search behaviour;
- Adjustments or activities to help them return to work/stay in work; and
- Improved mental health – specifically as a result of the integration of EA and therapeutic support.
- What are the key elements of the EA in IAPT integrated service that 'make a difference'?

Explore the benefits for staff/the EA in IAPT integrated service:

- What difference has moving to the 1:8 ratio made to the EA in IAPT integrated service? (e.g. improved access to, enhanced employment focus, opportunities to re-deploy staff, etc.)
- What, if any, have been the early benefits for staff/wider organisation?

1.6 Learning

Looking back across the programme, what has worked well and what less well? For who and why?

What are the key learning points for the Wave 2/future projects? What would be your recommendations to other CCGs?

- For preparing for the programme (including the training element);
- For implementing EA in IAPT; and
- For securing client outcomes.

Are there any changes or improvements you would like to see made to any aspects of the programme, building on what you have achieved so far?

Are there any critical elements that should be continued through to Wave two?

Finally, are there any other issues that the interviewee would like to raise?

Evaluation of EA in IAPT: Employability Partners Topic Guide

This is the topic guide for use in interviews with employability partners – defined as organisations which the EA's work with in their employment support role, so likely to include Jobcentre Plus and other local employment support providers (the latter might differ between local areas). The aim of the interviews will be to:

- Explore the employability partner's awareness and understanding of the programme, and views of the barriers facing the target group;
- Discuss their role in and experience of the programme;
- Explore their perspective on the rationale, design and delivery, outcomes and effectiveness of the programme; and
- The key lessons from their experience of the EA in IAPT programme.

Interviews will be semi-structured, undertaken face to face and will last around 40 -60 minutes. Interviews will be undertaken on the basis that no individuals will be identified and that all quotes used will be made anonymous; this will be made clear at the start of all interviews.

There will be a degree of variety in the interviews depending on the role of the stakeholder within the EA in IAPT programme. This means that the topic guide is designed to be flexible; it provides a framework for the discussions and is not a question-by-question guide.

1.7 Introduction

- Describe the purpose of the interview and the topics to be covered.
- Collect individual's job title, role and responsibilities
- Summarise the overall role of the organisation in terms of employment support, services provided, specific groups worked with and (spatial) areas covered.
- Ask for consent to record the interview. Explain that all interviews will be anonymised, and no-one will be named in reports. Explain that they can ask for the recorder to be stopped at any time and that they can change their mind about taking part any time during or after the interview.
- Explain that the interview is confidential. The only time confidentiality won't be kept is if there is evidence of likely or actual harm to them or to another person.
- Stress that if there is anything that we ask that they don't want to answer, then they don't have to.

1.8 General perspectives on employment advice for the target group

- Who do you think the key target groups are for the EA in IAPT service?
- What do you think the particular needs of the target group are/the barriers to employment they face?

- Can you briefly describe the local employment support service landscape?
- What specific challenges do existing employment support services face in meeting these needs?
- With the exception of the EA in IAPT programme, are you aware of any other initiatives aimed at supporting the target group in your area?

1.9 Awareness and Understanding of EA in IAPT

This section explores the interviewee's awareness and understanding of the EA in IAPT programme.

- Are you aware of the EA in IAPT programme, and the investment in increasing the number of EAs in your area?
- Were you/your organisation involved in development of the EA in IAPT programme? If so how?
- How was the programme introduced to you? When, who, how?
- What is your understanding of the aims, objectives and key features of EA in IAPT?
- Are you aware that the programme is aiming to support people to find, return to and remain in work?
- What is your view of the rationale for the additional investment? What are the strengths (and any weaknesses) of the model? Is it addressing the right problem in the right way?

1.10 Involvement and Role

This section explores the organisation's role and involvement in the programme.

- Summarise your role in the EA in IAPT programme – probe for involvement in taking referrals from it, referring to it, additional support to EAs, etc.
- How long has your organisation/you been involved in the programme?
- Can you provide indicative numbers of referrals, contacts etc. from IAPT staff (therapists and EAs) and clients?
- Can we discuss your experience of working with the programme – *coverage depending upon involvement, but to include: quality of referrals received/targeting, decision making on referring to IAPT, working with IAPT customers, etc.*
- How effective are communication arrangements between your organisation and the EA in IAPT team?
- Since the investment in additional EAs, have you noticed any change in the volume or nature of referrals received? Any changes in the type of support – help to find work/return to work/stay in work?

1.11 Early Benefits and Impacts

This section explores the early benefits and impacts from the interviewee's perspective.

For claimants:

- To your knowledge, what have been the main 'employment' benefits/impacts for EA in IAPT service participants? *To cover employment secured, sustained (return to work, stay in work), improved attitudes to work, improved employability, increased/improved jobsearch, adjustments to help stay in work/return to work etc.*
- And have you noticed any wider benefits amongst the claimants you work with? *Probe for improved confidence, resilience, enthusiasm, self-esteem, presentation, health and well-being etc.*

For local employment provision:

- Thinking about the EA in IAPT service itself, have you noticed any benefits from the increased numbers of EA's? – *e.g. more rapid access to employment services for clients, improved provision (reflected in interactions with claimants), fewer delays in appointments, increased interaction between EAs and your organisation, etc.*

1.12 Early Lessons

This section brings together the key lessons for future provision.

- In your view, how effective is the EA in IAPT programme in achieving its objectives?
- What has been the key learning for you from your experience of the EA in IAPT programme, and the recent investment in additional capacity?
- In your view, what is working well/potential good practice? Why? What are the key enablers?
- What is working less well? Why? What are the key barriers? What could be improved?
- If there are any areas where performance could be improved, what are they and what improvements could be made? Explore for clients and communication between services.
- Is there anything that your organisation, and other employment services, can do to maximise the benefits of EA in IAPT?

Thank and close

Appendix A.2 Letter of invitation to case study sites

Re: Your participation in the evaluation of Employment Advisers in IAPT

Dear

I hope this message finds you well. Its purpose is to ask for your involvement in the above Service Evaluation, which provides an opportunity to use evidence to improve outcomes for people accessing Employment Adviser (EA) in IAPT services.

As you may know, WHU has commissioned an independent evaluation of EA in IAPT. More information about the evaluation can be found via the links below, but in summary:

- It is being undertaken by a partnership of independent research organisations made up of IFF Research, ICF Consulting, the University of Sheffield and Bryson Purdon Social Research (BPSR);
- The evaluation focuses on both process learning and evidence of impact; and,
- Evidence is being gathered from multiple sources – including qualitative interviews, client surveys and analysis of the IAPT and other relevant datasets.

One important component of the evaluation is a series of **eight case studies** of local EA in IAPT provision. We have selected [NAME OF CCG] as one of these potential case studies. We understand that you are the provider for this CCG and we would like to invite you to take part.

The case studies are quite 'light touch' and will not require significant inputs from you or your staff. They will involve:

- Face to face interviews with employment advisers, senior employment advisers and therapists;
- Telephone interviews with a sample of people who have accessed employment advice along with the IAPT service; and
- Telephone interviews with local employability partners.

This would be discussed and planned with you before the work commences.

We are aiming to begin fieldwork with staff in August and anticipate that this might extend to September to allow for people being on holiday over the summer. Interviews with people accessing the service will take place later.

I hope that this represents a welcome opportunity and we would certainly value your participation. If you are happy to take part, then please let us know by responding to this email by the end of June/first week in July.

In the meantime, please don't hesitate to get in touch if you have any questions about this work.

With best wishes

[NAME]

For more information on the evaluation please follow the links below

Ethical protocol

Appendix