March 2015

THE WORK FOUNDATION
PART OF LANCASTER UNIVERSITY

An Evaluation of the 'IPS in IAPT' Psychological Wellbeing and Work Feasibility pilot

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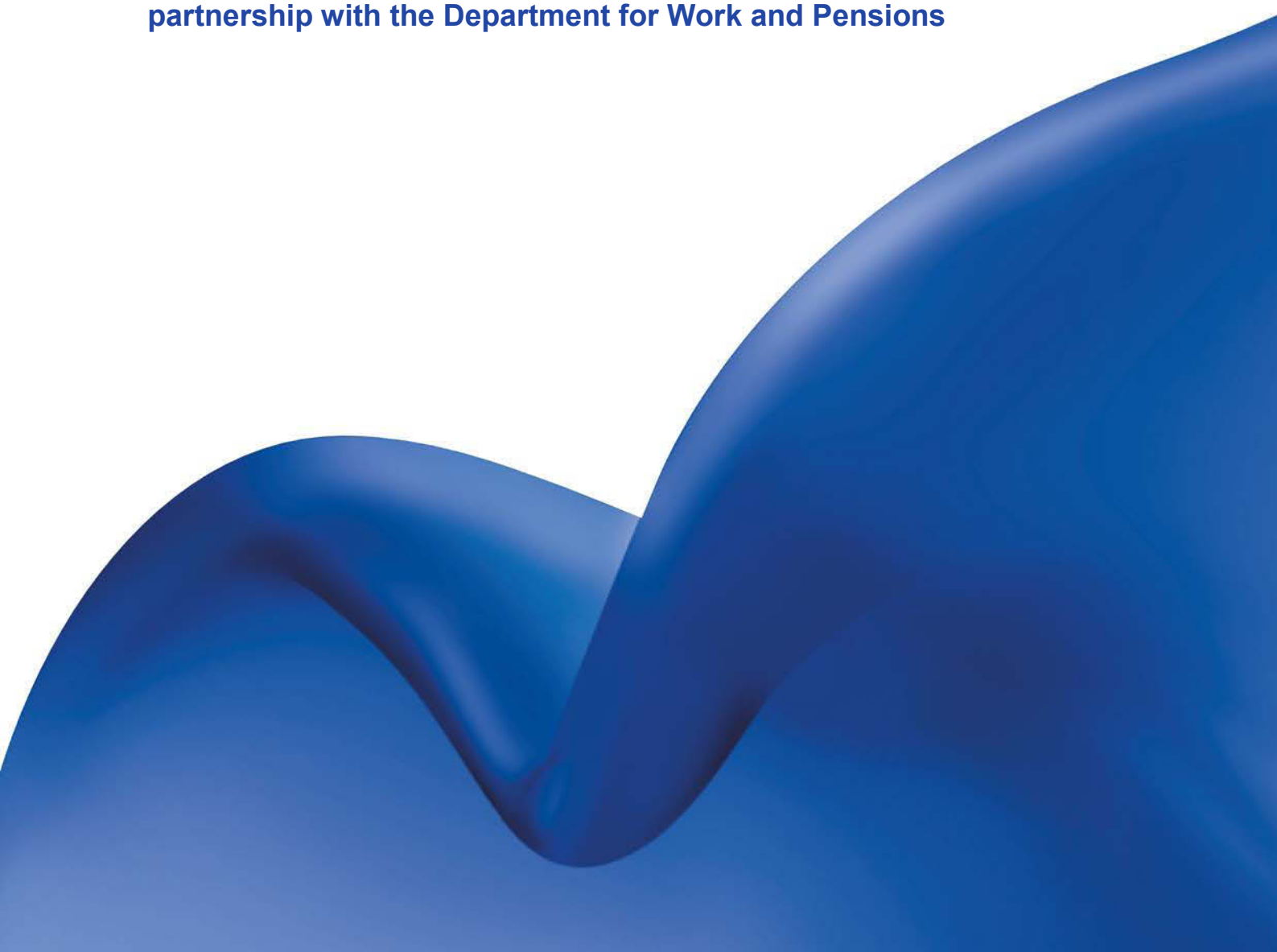
This report was commissioned by the Department of Health in partnership with the Department for Work and Pensions



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Executive summary

Introduction

This report is an evaluation of a pilot service which provided embedded vocational support, based on the Individual Placement and Support (IPS) model, into the Increasing Access to Psychological Therapies (IAPT) programme. The 'IPS in IAPT' pilot ran from June 2014 to December 2014 in four sites in England (sites A-D). A total of 413 people were referred to the four sites, 173 declined to take up the opportunities leaving a total of 240 participants.

This was one of four pilots commissioned by Department of Health (DH) and Department for Work and Pensions (DWP), informed by the 2014 report by RAND Europe on *Psychological Wellbeing and Work: Improving Service Provision and Outcomes*. These small-scale, feasibility pilots and their evaluations were to test the design detail of the models proposed, methods of tracking findings and the initial effects. In particular they were designed to test which type of increased support best improves service users likelihood of moving closer to work or into work, as well as highlighting any health and wellbeing outcomes.

Method

This evaluation sought to answer a number of research questions, defined by DH and DWP for use across the four pilots. Questions can be found below. Research was undertaken with IPS employment specialists, service managers, Jobcentre Plus (JCP) Employment Support Allowance (ESA) Work Coaches, and service users – made up of specified groups of ESA JCP clients. Information on service usage, and health and employment measures was also collected from service users who consented to participate in the evaluation. Measures used were GAD7, PHQ9, the WHO Five Wellbeing Index, and a Job Search Self-Efficacy scale. These measures were to be taken with service users at the start and end of the intervention, though the latter was achieved only rarely due to insufficient time within the pilot to complete the IAPT intervention.

Analysis of findings

All groups of participants taking part in the evaluation were very positive about the 'IPS in IAPT' pilot intervention. The continuation of this intervention was well supported across the board.

1. What is the most effective form of the intervention?

What parts of the intervention were most/least effective?

The pilot intervention was characterised by the extent of partnership working involved between the three parties: IPS service providers, IAPT service providers, and Jobcentre Plus. Though this was effective in principle and in terms of overall service provision, in practice there were many barriers to effective partnership working, including a lack of time to

engage partners and the delay in access to IAPT, preventing parallel service provision. Also important was the fact that it provided employment support outside of the jobcentre environment – something highly valued by service users who appreciated the flexibility and lack of pressure compared to Jobcentre provision.

What were the operational challenges?

The main operational challenges centred on the lack of time provided to set-up the pilot – in terms of employing and preparing staff, embedding services, and establishing links and processes with partner bodies. Time taken for management of the pilot and for administration was also problematic. However, the short timescale for the set up and delivery of this pilot was necessary to ensure that key learning was available to inform the design of the larger-scale trialling of the programme.

How could interventions be improved for a larger scale trialling programme?

Suggestions for improvement of a larger scale pilot also revolved around time. Participants felt there needed to be more time for set-up, and more time for the pilot itself – to increase numbers of service users achieving employment outcomes, e.g. by allowing sufficient time for service users to experience the services within the pilot, and to build relationships with local employers. The speed with which access to IAPT could be achieved was a substantial issue, with the long waiting lists making parallel service provision unlikely within the pilot time frame. Improving engagement with the JCP was also emphasised, enabling better efficiency and higher levels of referral.

2. What is the most effective delivery model?

What worked well/didn't work well during the referral process?

Different sites had quite different referral processes and referral issues. Difficulty identifying appropriate clients for the pilot was experienced by a number of JCPs, for example due to a slow pace of new JCP referrals caused by delays with Work Capability Assessments, or misunderstandings about the eligibility criteria. The latter also led to many inappropriate referrals – often where people were unsuitable for IAPT as they were already receiving a therapeutic intervention, or were assessed as having too severe a mental health condition for this level of support. Misunderstandings around the referral process due to poor communication between partners, and particularly with the JCP, prevented higher numbers of successful referrals being made. Changes had to be made to the pre-existing referral processes which received only GP referrals and, in some cases, self-referrals, there was nothing in place to receive referrals from JCPs. Some people were also removed from the pilot due to NHS adherence to a strict policy of offering patients only one or two further appointments if they did not attend the first appointment (and the second appointment). A further difficulty was found in the administration and data management for the project – particularly the complexity of sharing service user (patient) data across ad hoc data collection systems, and in the time required to collect and compile data.

What are the drivers for clients participating/not participating

Access to psychological therapy was identified, by The JCP ESA Work Coaches and other participants, as the main reason services users chose to participate in the pilot. In some cases it was misunderstood that the pilot would provide speedier access to IAPT. Conversely, eligibility to psychological therapy was also a reason for non-acceptance in the pilot, with JCP ESA Work Coaches and others highlighting that many potential service users had previously undertaken therapy, were already accessing treatment, or simply decided after all that they did not want therapy, and therefore could not participate in the pilot. Access to employment support was also a main driver for participation, with service users keen to access additional support to find work. There was little feeling across participants that service users felt compelled to take part in the pilot out of concern around the potential effect on their benefits if they did not, though one JCP ESA Work Coach showed overt concern that linking IAPT to the Jobcentre may inspire a more negative view of IAPT among potential service users.

How has the support influenced the behaviour and attitudes of participants?

IPS service users experienced an increase in confidence and in motivation as a result of the pilot. This encouraged people to seek jobs and to take up work opportunities, in a way that they previously did not feel ready for. In many cases this was irrespective of whether they had also received IAPT, given many had not at the time of interview.

Was their variation across pilot sites, and from the original specification?

Four main ways were identified in which there was variation between different pilot sites, and in some cases from the original pilot specification. There were different: operational models – such as IPS and IAPT provided by separate organisations or the same organisation; referral processes and data collection – managed by IAPT or managed by the separate IPS organisation; quality of IPS services (levels of fidelity to the IPS model); and, levels of partnership working and engagement – how effectively the organisations in an area worked in collaboration.

Given the short-time for the pilot, and the variation in how developed different IPS services were, it is not possible to say which model worked best. The highest numbers of employment outcomes (new paid employment) were achieved from Sites A and Site D, both of whom had an existing IPS service, which had achieved Centre of Excellence status.

3. Did the measure have an impact on employment related outcomes?

Fifteen service users achieved paid work as a result of the pilot – there were however 16 paid job outcomes, as one participant achieved two different paid outcomes at different times during the pilot period. All were in site A and site D. Of those who consented to participate in the evaluation a total of 43 made job applications (average of four each), and 23 attended job interviews (average of two each). Within the 15 who achieved a paid job, a total of 82

job applications were made, and 26 job interviews attended.

Only site A and site D completed and returned both the start and the end data for the Job Search Self-Efficacy questionnaires (n=43). Average score at the start of IPS was 24, increasing to an average of 31 by the end of IPS – a change of + 7 points. Among those who found employment, change was +10.

4. Did the intervention have a measurable effect on the mental health-related outcomes?

Despite limited data being provided, given the small number of service users (n=10) who 'completed'; their IAPT treatment within the pilot timeframe, scores from the GAD and the PHQ showed a positive effect on health and wellbeing for those who participated in the pilot – both measures showed a change of -3.3. Sufficient data was not available for the WHO Wellbeing measure.

Conclusions

Across the different participant groups, and across the pilot sites, there was considerable positivity about the IPS and IAPT service, including in those sites that did not already have a similar service in place. Fifteen service users found paid employment, and many other service users achieved other employment-related outcomes, and experienced an increase in heath and wellbeing, and job search self-efficacy.

Identified during the evaluation were a number of limiting factors that reduced the ability of the pilot to achieve higher numbers of service user participants and job outcomes. There was considerable variation as to how well sites performed, with some sites struggling to get referrals, and high drop-out levels. Factors are summarised here:

Low number of referrals and variation across sites: Reasons for this were identified as the restrictive eligibility criteria, misunderstanding of the criteria, and difficulties identifying suitable candidates. This was driven by a lack of lead-in time to improve JCP capacity in this regard. Unclear or complicated processes for managing referrals also created issues.

High numbers of drop-outs: Drop out rates for both IPS and for IAPT varied considerably between sites. Difficulties with contacting service users was a primary issue, with service users getting 'lost' as they moved between the IPS, IAPT and JCP services. Some people stated that they felt their wellbeing had deteriorated in the period between initial interest and first appointment. This deterioration of wellbeing, and inappropriate referrals were other reasons why services users were not retained in the pilot, as was people changing their mind about wanting to undertake the IAPT aspect of the service at the initial appointments.

Inability to provide parallel IPS and IAPT service delivery: Waiting lists for the IAPT component joined with the short time for the pilot meant that service users rarely experienced parallel delivery of IPS and IAPT. Though people could access IPS while waiting for IAPT, many preferred to wait for IAPT.

Insufficient time to deliver services or develop good partner relationships: Engagement with and buy-in from IAPT and JCP was limited by the lack of lead-in time. This had implications for, for example, the numbers of referrals made into the project, and the ability to collect health and wellbeing data on service users. The short time frame for the pilot also meant that many services users did not receive support, or the pilot ended before they had 'completed' support.

Inconsistent fidelity to the IPS model: Not all IPS services were able to provide support which was fully reflective of the principles of IPS, given the lack of time for set up and for them to provide ongoing support to service users. Not all pre-existing IPS services had achieved centre of excellence status, while the new service had necessarily never been fidelity assessed (though employment specialists were fully trained).

Incomplete data on measures: Difficulties in collecting the Management Information for this project were largely due to data being required from two different services, which were not necessarily co-located. There was no additional funding for data management, and its collection was achieved only through the buy-in of individuals with sufficient time from both IPS and IAPT services. Of particular note was whether IAPT participants were aware of the need to complete the additional WHO wellbeing measures, and poor collection of final score data across measures.

Recommendations

Recommendations have been made to inform the development of a larger scale pilot.

1. **Increase time for the pilot**, in terms of more time for:

    - **Set-up:** at least 6-8 weeks set-up time, to provide sufficient opportunity for recruitment and training of employment specialists; to market the service to potential users; to obtain buy-in from IAPT and JCP, and to develop appropriate referral routes and processes.
    - **The service to embed:** at least 12 months is required for the operation of the pilot, to allow parallel delivery of IPS and IAPT; to allow services users to complete IAPT and IPS (i.e. in-work support); and, to allow time for quality improvement within the pilot.
    - **'Wind-down' support** after the pilot has finished, to allow time for services users to complete IAPT, and to ensure appropriate alternative support is available for those still in IPS.

2. **Enhance the partnership relationship between IPS and IAPT providers**

Active steps must be taken to enhance the relationship and partnership capacity of IPS and IAPT services. This includes improving knowledge of each other's services, and facilitating joint-working arrangements and shared responsibility for the pilot.

3. Enhance parallel provision of IPS and IAPT services

Consideration should be given to the provision of additional financial support to IAPT for the pilot to enhance their ability to provide timely psychological support to service users.

4. Enhance partnership working with Jobcentre Plus

Engage JCP ESA Work Coaches at earlier stage in the pilot development, and on an ongoing basis, to encourage buy-in and joint-working, to support the development of an appropriate service to which they are comfortable referring clients.

5. Permit the option for IPS without IAPT

Allow service users to opt for IPS without IAPT support, particularly those who have previously (or are currently) engaged with therapeutic support.

6. Local project/service manager to be assigned to each pilot site

A designated, funded 'project manager' role at each site to provide a number of functions, including the management of relationships and partnership working between the IPS, IAPT and JCP, as well as data sharing, collection and referral management.

7. Consider broadening of eligibility criteria

Other ESA and JSA clients were suggested to be likely to benefit to access to the IPS and IAPT service, particularly as an alternative to the Work Programme for those with mental health conditions.

8. Improve communication with clients/service users

Develop and provide user-friendly, plain English communication about the pilot to potential services users, clearly outlining what the services offer, the processes involved, and the timeframe in which it is expected to occur.

9. Improve data collection and data management

Funded provision of data management support and resources for sharing and managing data is required, as is time to plan how data might be managed in this context, particularly given the need for securing shared data, due to the involvement of NHS patients through IAPT.

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Chapter 1 Introduction to the pilot

1.1. Background to the pilot

The Department of Work and Pensions (DWP) and Department of Health (DH) are undertaking work to develop reformed and/or innovative approaches with the aim of improving employment outcomes for people with common mental health problems.

In 2013 DWP and DH commissioned RAND Europe to answer the question *"What is the best approach to improve employment outcomes for people with common mental health problems (both diagnosed and undiagnosed)?"* This was driven by increased awareness of the prevalence of mental health problems among the working age population (up to 18 per cent at any one time) (McManus, et al., 2009), and the knowledge that mental health problems are highly prevalent among those claiming sickness benefits – with four out of 10 new claims due to mental health conditions (van Stolk, et al., 2014; OECD, 2014).

After a period of research and consultation with experts, RAND Europe released their report in January 2014, entitled: *Psychological Wellbeing and Work: Improving Service Provision and Outcomes* (van Stolk, et al., 2014). The report recommended the development of four models of support.

1. Embedding vocational support, based on the IPS model, in IAPT.
2. JOBS II model, to build self-efficacy and resilience to setbacks that benefit JCP clients face when job seeking.
3. Jobcentre-commissioned, third-party provision of combined telephone-based psychological and employment related support.
4. User research to inform online mental health and work assessments and support.

A series of small-scale pilots of the recommended models, known as the Psychological Wellbeing and Work Feasibility pilots, were commissioned by DWP and DH. These occurred in late 2014/early 2015.

Evaluations of the pilots were undertaken to test the design detail of the four different intervention models, and to understand how to improve employment outcomes for people with (diagnosed and undiagnosed) common mental health problems who are in and out of work. Specifically, the evaluations were designed to explore and establish the evidence for:

1. A case to support or otherwise that the pilots should be taken forward into large-scale piloting.
2. Insight into the relative performance of interventions.

3. Learning from the implementation of the delivery models and issues for wider piloting.

The following report provides an evaluation of the first pilot which tested whether embedding a specified employment support model (Individual Placement and Support, known as IPS) has been successful in improving the employment outcomes for people with common mental health conditions in a primary care setting (Improving Access to Psychological Therapies, known as IAPT), as well as testing any effect on health and wellbeing.

More information on this model and the pilot is provided below.

1.2. Embedding vocational support, based on the IPS model, in IAPT

The RAND Europe report described the proposed 'IPS in IAPT' pilot as follows:

> **1) Embed vocational support based on the Individual Placement and Support (IPS) model in IAPT or other suitable psychological therapy services.**
>
> IPS is a fidelity/specified model and has been tested in secondary care settings for people with severe mental illness. IPS would be offered through IAPT (as currently is the case in some locations) and referrals to the IPS service would be made by IAPT therapists. A greater group of individuals with common mental health problems would be able to access to evidence-based support that addresses both their mental health problem and supports them into employment. This option would also place more employment advisers (EAs) in primary care, and increase the number of EAs overall.
>
> On the basis of available evidence, we estimate a benefit-cost ratio of 1.41. This means that for each £1 spent to achieve an employment outcome, the Government would save about £1.41. This option has a relatively high cost per participant (about £750) and appears particularly effective in terms of achieving an employment outcome compared to the other options proposed.
>
> *Source: van Stolk, et al. (2014), p9*

1.2.1 What is Individual Placement and Support?

Individual Placement and Support (IPS) is an approach to supported employment developed in the 1990s in the USA (Drake, 1998). The model represents a shift away from traditional prevocational models of vocational rehabilitation. It is characterised by its focus on rapidly seeking paid employment for service users ('place then train') rather than spending time preparing people for work ('train than place'). Integration of employment support with the individual's mental health care and treatment is also seen as key to IPS. These characteristics form part of eight principles which when followed closely have been shown to increase the effectiveness of the model (see box 1.)

Box 1: Eight Principles of Individual Placement and Support.

1. Competitive employment is the primary goal
2. Everyone who wants it is eligible for employment support
3. Job search is consistent with individual preferences
4. Job search is rapid: beginning within one month
5. Employment specialists and clinical teams work and are located together
6. Employment specialists develop relationships with employers based upon a person's work preferences
7. Support is time-unlimited and individualised to both the employer and the employee
8. Welfare benefits counselling supports the person through the transition from benefits to work

Source: Sainsbury's Centre for Mental Health (2009)

The model is delivered to individual service users by workers who are specialised in giving employment advice and support. Caseloads for employment specialists are kept small – a maximum of 20 per full-time employment specialist. Employment specialists seek out employment opportunities which suit the individual, for example regarding interests, type of job, location and hours. Employers may be contacted directly to find "hidden" jobs which are not openly advertised. Once appropriate employment is found, intensive and on-going in-work support is provided to individuals to increase the sustainability of employment.

The effectiveness of this model of support has been demonstrated with people with severe mental health conditions, in particular schizophrenia. Compared to traditional pre-vocational models, IPS supported employment has been found to be more effective at helping people with severe mental illness obtain competitive employment, in addition people in supported employment earned more and worked more hours per month than those who had prevocational training (Crowther, et al., 2001).

1.2.2 What is Improving Access to Psychological Therapies?

The Improving Access to Psychological Therapies programme, known commonly as IAPT, is an NHS run service, introduced in 2008 to significantly increase the availability of NICE recommended psychological treatments for common mental health conditions, such as anxiety and depression. In the last three years, more than one million people have been treated in IAPT services, more than 680,000 people completed a course of treatment and more than 45,000 people were helped off sick pay and benefits (Department of Health, 2012).

IAPT services are commissioned by Clinical Commissioning Groups (CCGs). They are usually provided by local NHS Trusts, or by consortia led by the NHS or a third sector organisation. Access is usually through referral from a GP or individuals may self-refer. Upon referral, an individual will be assessed to ascertain eligibility and the level and type of support that will be appropriate (e.g. high or low intensity therapy). Support may be computerised, via the telephone, or delivered face to face.

IAPT is open to those both in and out of work. In its original design IAPT had a strong emphasis on how to help people with common mental health problems to retain or gain work. It was envisaged that there would be one specialist employment advisor for every eight IAPT therapists (Layard, 2006, cited in: van Stolk, et al., 2014), though unfortunately this ratio has not been achieved.

1.2.3 The delivery of the pilot model

The pilot ran from 23rd June 2014 until 31st December 2014 – just over six months. It was envisaged that pilot participants would receive IPS and IAPT services in parallel during this time. New referrals into the IPS and IAPT service were stopped on the 31st October, to allow time for support to be delivered within the pilot timeframe.

Pilot delivery

The Centre for Mental Health was commissioned to deliver the pilot.

The pilot was delivered in four sites in England. Three of the sites had experience of delivering an IPS service, for Sites A and D this was only within the NHS Trust providing secondary mental health care, and for site B within the Healthy Minds (IAPT) and Wellbeing Service (Primary Mental Health Care). Sites A and D had been assessed as IPS Centres of Excellence[1] for people with severe and enduring mental health conditions in secondary care. The fourth site (Site C) was set up especially for the pilot, though there was a history of providing employment support alongside IAPT. Two of the pilot sites had co-located IPS and IAPT services with a shared service manager (Sites B and D), while the other two had separate services.

For more information on the sites see Appendix A.

Sample criteria

Eligible for participation in the pilot were ESA JCP clients with a mental health condition of stress, anxiety or depression and who are either:

- in the Work Related Activity Group with a prognosis of 12 to 17 months, but not yet referred to the Work Programme; or,
- in the Work Related Activity Group with a prognosis of 12 to 17 months, and already exempted from the Work Programme; or,
- returners from the Work Programme who do not have a prognosis of 18 to 24 months; or,
- in the Work Capacity Assessment (WCA) phase and likely to benefit from the

[1] http://www.centreformentalhealth.org.uk/employment/centres_of_excellence.aspx [accessed 6 Jan 2015]

intervention (where districts already engage or are planning to engage).

On 5th August eligibility was extended to include any claimant in the above groups with a mental health problem, which did not have to be listed as the primary reason for claiming benefit.

Eligible clients were invited to participate in the pilot via their Jobcentre ESA Work Coach. Clients were asked whether they would like to access the complete 'IPS in IAPT' service, or if they would like to receive IAPT support only. It was anticipated that 250 service user per site would enter into the pilot.

It was originally envisaged that participants would enter the pilot (and therefore the evaluation) through RCT design, where they would be randomly assigned either IAPT (as the control), or IAPT and IPS. It was expected that at least 500 participants would be entered into the IPS in IAPT service, while 250 would form a 'control group' undertaking IAPT only. However, the level of ethical approval required to allow participants to be randomly assigned as described was not seen as possible to achieve within the time constraints of the pilot, and therefore this was not a feasible approach. Therefore people were accepted onto the IPS and IAPT provision on a voluntary basis, while those who did not wish to receive IPS in IAPT were able to opt for IAPT (as usual) or to not receive any service.

Entry into pilot

It was originally envisaged in the RAND Europe report that referrals to IPS would be made from IAPT or via GPs. However, the need to identify specific ESA clients for the pilot meant that the JCP was an appropriate point of identification and referral. ESA clients received advice from JCP ESA Work Coaches about the pilot and both the IPS and IAPT service provision. Consent was sought from participants to enter the pilot.

Those who consented to participate in the pilot were provided with details of how to refer. Referral processes differed at different sites due to various factors, including whether there was a pre-existing IPS service, whether IPS or IAPT were the single point of contact for referrals, how closely integrated the IPS was with the IAPT service, and the size of the pilot area. Pilot sites nominated a single point of contact for referrals to be made to. For example, pilots sites may have had a dedicated individual person as the point of contact specifically for self-referral to the pilot, or they may have used their services existing phone line, and then triaged people depending on whether they were pilot referrals, or business as usual referrals.

Where the single point of contact for referrals was located in IPS, service users were provided with details on how to self-refer to IAPT. Upon self-referral, IAPT services contacted clients for assessment and triage. Where IPS and IAPT services were co-located, the IAPT self-referral was undertaken first and then service users were referred to IPS. Consent for participation in the evaluation was sought by the first point of contact with IPS and/or IAPT providers.

Chapter 2 Method

In the following section we outline the objectives of the evaluation, and the methodology and measures used to conduct it.

2.1 The objectives of the evaluation

The purpose of the small-scale, Psychological Wellbeing and Work Feasibility pilots, was to test the design detail of the intervention models, methods of tracking findings and initial effects. The pilots were designed to test which type of support best improves JCP clients prognoses and their likelihood of moving closer to work or into work. They also considered whether there were wider benefits, including improved mental health and wellbeing.

Findings from the pilots are also to inform future considerations on what types of support best assist JCP clients with employment and mental health needs to move closer to the labour market – informing decisions about next steps including whether to proceed to larger-scale trials of the most promising interventions.

The objectives for the evaluation of this pilot were:

1. **to provide insight into the effectiveness of the pilot in supporting employment for people with mental health conditions**. Including: information on the acceptability of the intervention; insight into the practical operations of the first phase pilot; information on health and wellbeing of participants; and,

2. **to make recommendations about whether the first phase pilot should be taken forward into large-scale piloting**. Including: recommendations to support the design of a scaled up pilot, should the first phase pilot be taken forward; and, recommendations about the evaluation of a scaled up pilot, should the first phase pilot be taken forward.

The evaluation was conducted by The Work Foundation, an independent not-for-profit research organisation.

2.2 Research questions

Evaluation questions were provided by DWP and DH. These were used across all four pilots to allow comparison of findings. Questions one and two were to be addressed primarily through qualitative exploration, while questions three and four to be primarily informed by Management Information data on service use and outcomes (measures are described in 2.4 below).

1. **What is the most effective form of the intervention?**

- What was the provider staff's experience of delivering the pilot?
    - What parts of the intervention were effective / less effective from their point of view?
    - How has the support influenced the behaviour and attitudes of participants?
    - What were the operational challenges?
    - How could the interventions be improved for a larger scale trialling programme?
- What were the service users' experiences?
    - What parts of the intervention were effective / less effective from their point of view?
    - How has the support influenced the behaviour and attitudes of participants?
- How did the intervention vary across areas?
- Where a specified model was commissioned where did the pilot depart from the specification and why?

2. **What is the most effective delivery model?**

- What are the drivers for JCP clients participating/not participating?
- What are the drivers for participants completing/not completing?[2]
- What worked well / didn't work during the referral process and why?

3. **Did the measure have an impact on employment related outcomes?**

4. **Did the intervention have a measurable effect on the mental health-related outcomes?**

These questions were used to frame the evaluation method. Answers to these questions can be found in the 'analysis of findings' section below.

[2] This question was not answered in the analysis due to limited ability to 'complete' the IPS in IAPT service. The issue of non-completion is discussed in section 3.2.

2.3 Participants

The evaluation engaged with four groups of stakeholders:

- Employment specialists
- Service managers
- Programme participants/service users
- Jobcentre Plus ESA Work Coaches

Researchers visited each of the four pilot sites in October 2014. Researchers also participated in fortnightly teleconferences with representatives from each pilot site and the Centre for Mental Health to be kept up to date on project progress, and to inform service providers of the evaluation process and progress.

Employment specialists

Focus groups were held with 3 to 5 employment specialists at each site. Focus groups lasted approximately 45-60 minutes, and were conducted on-site.

Service managers

Interviews were conducted with the service manager at each site. Interviews lasted approximately 30-45 minutes, and were conducted on site. The service manager was either responsible for just the IPS service, or the IPS and IAPT service depending on the site.

Jobcentre Plus ESA Work Coaches

A short online survey was distributed to JCP ESA Work Coaches at each of the four pilot sites. The development of the survey was informed by informal discussions with JCP advisors during site visits. Though the survey was largely quantitative, space was provided for additional comments, which were utilised in the qualitative analysis.

The survey was open on the 5th November for three weeks. Invitations to the survey were disseminated through JCP district managers.

There was an 80 per cent response rate from JCP ESA Work Coaches – 45 respondents (2 incomplete) out of a possible 56.

- Site A: 42 per cent of total responses, 80 per cent of site sample population
- Site B: 7 per cent of total responses, 18 per cent of site sample population
- Site C: 27 per cent of total responses, 100 per cent of site sample population

- Site D: 24 per cent of total responses, 85 per cent of site sample population

A reason provided for low response rate of Site B was that not many JCPs actively engaged with (or made referrals to) the pilot. Engagement of JCPs is discussed further in section 3.1.

Service user participants/JCP clients

Telephone interviews were conducted with 12 service users. Interviews lasted approximately 15-30 minutes. Service user participants were selected based on their engagement with the pilot (i.e. having had at least three IPS appointments), and their having consented to participate in the evaluation and be contacted by researchers. Though it was envisaged that we would interview three people from each site, given the criteria and the differing performance of pilot sites this was not possible. Six participants were from Site A, zero from Site B, two from Site C and four from Site D.

De-identified management information was collected on an ongoing basis by IPS and IAPT services on service user participation and progress. The final data collection was provided on 15th December 2014.

Collected data included: Anonymised identification data; consent data (for pilot and evaluation); engagement with IAPT; engagement with IPS; reasons for withdrawal from IAPT and/or IPS services; health and wellbeing scores; job-seeking self efficacy scores; job search and employment outcomes.

More information on the scores and measures used are provided below.

2.4 Measures

A number of measures were prescribed by DWP and DH for use in this pilot. These measures were used across the four Psychological Wellbeing and Work Feasibility pilots.

Scores on the measures were to be collected pre- and post service use, i.e. at the first and last appointments. Three of the measures were for collection by IAPT providers: PHQ-9[3] and GAD-7[4], which are collected as usual by IAPT providers, along with an additional measure, the World Health Organisation (WHO) Five Well-being Index.[5]

IPS providers were also asked to use a measure of Job Search Self-Efficacy (JSSE) provided by DWP. The measure involves nine questions on a five point Likert scale. The scale is available in Appendix B.

[3] Available from: http://www.patient.co.uk/doctor/patient-health-questionnaire-phq-9 [accessed 7 Jan 2015]
[4] Available from: http://www.patient.co.uk/doctor/generalised-anxiety-disorder-assessment-gad-7 [accessed 7 Jan 2015]
[5] Available from: http://www.psykiatri-regionh.dk/who5/menu/ [accessed 7 Jan 2015]

2.5 Ethics and consent

Written consent was sought from service users for their participation in the pilot. This was provided by JCP ESA Work Coaches. Participants were given the choice of accessing the IPS and IAPT service, just IAPT (and 'as usual' service) or declining all services.

Upon referral, service providers provided literature to explain the evaluation and its purpose to service users, and written consent sought for participation. Consent was sought for both the use of management information data in the evaluation, as well as consent to be contacted for interview. Consent to interview was verified verbally by researchers when they made contact with the service user to arrange the interview.

Employment specialists and managers were asked to complete a consent form which was provided to researchers prior to interviews/focus groups. JCP ESA Work Coaches were provided with information on the evaluation at the start of the online survey.

Ethical approval for the evaluation was sought and obtained from Lancaster University. Additional ethical approval from NRES was not required as service user participants were recruited through the JCP, rather than through IAPT (an NHS service).

Data protection

The management information data was provided to researchers by IPS and IAPT service providers on a password protected spreadsheet. Interviews were recorded and transcribed. Recordings were deleted after transcription, and transcripts stored securely.

Chapter 3 Analysis of findings

In the following section we explore findings from the data collected during this pilot. The analysis has been conducted utilising the research questions provided by DWP and DH (see section 2.2), though the order of questions has been changed for ease of comprehension.

Analysis is split into two sections. The first addresses the qualitative research questions identified by DWP and DH (questions 1 and 2). The second section looks primarily at the management information on service use, and addresses the quantitative questions identified by DWP and DH (questions 3 and 4).

3.1 Qualitative research questions

The analysis has been arranged to provide response to questions (and related sub-questions) one and two outlined in section 2.2 of this report. Thematic analysis conducted on the data collected from all four participant groups (employment specialists, service managers, service users, and JCP ESA Work Coaches) was conducted with consideration of the provided questions. Priority was given to those themes that were identified across participant groups to enhance triangulation of findings.

Quotes from participants in the evaluation have been used extensively throughout this section.

3.1.1 Value of the pilot to participants

Though not included in the initial research brief, it was felt worthwhile to consider the overall value of the services provided in the pilot to both service user and service provider participants.

Feedback from service providers was overwhelmingly positive.

It works. And we've seen it work, we know it can work… It would be nice to see it become permanent. There's no doubt whatsoever in our minds that it will work, and I am sure the jobcentres will tell you the same thing, they're crying out for something like this. It's just, it's not rocket science, it's just how you deal with an individual. Employment Specialist

I think from our experience, it's been great, a fascinating experience to be part of the pilot really because you can see it working. Employment Specialist

I think it's a fantastic – I think if it can be rolled out it would be fantastic. I think it's really good for clients because there is a massive gap in the market from the client group. And I do feel it would really help clients, and it would really improve the unemployment rate, and mental health needs. Service Manager

It works really really well. All the therapists are very complimentary and they think it's a fabulous service. Service Manager

We need it to continue!! JCP ESA Work Coach

Any support for people with mental health conditions is welcomed. JCP ESA Work Coach

Service user participants were also extremely positive, describing how much the IPS and IAPT service had helped them as individuals, where options had appeared limited.

All I can say is the service I've had has been absolutely fantastic so I can't think of anything else that would enhance it really. Service User

I think it was the best idea, and I think it's brilliant. Service User

I can't tell you how much it's helped me actually, I've come on more in the past few weeks, for the past eight weeks, than I ever would have if I hadn't had [service name] *behind me. I would still be where I was eight weeks ago because I had nowhere to turn… So I can't say enough how much help it's been.* Service User

…it is a mental state that you have to be in, you have to be in a certain place mentally to be able to do things and I feel as though this is actually, the best I've felt about going back to work for quite a few years. I think it's very valuable, absolutely, without a doubt. Service User

Some went on to highlight the helpful role the service had had for family/carers who had been providing them with support.

It worked really well, and I just think it needs to carry on going and work really well for other people. I just think…it's brilliant, I can't fault anything, it's been good for me, a good thing for my mum because she's had to put up with me for the last how many years. And I wish I was in the service a lot longer ago because I'd happily send anyone that way. Service User

Service user participants were positive about both the IPS and the IAPT support package, as well as the individual IPS and IAPT services.

This service is acting as a bridge between all those things isn't it? So this service is getting you access. If you've got a mental health issue, you might be banging your head against a wall with your doctor to get the right thing you need…the jobcentre can't refer you, they can't tell your doctor what to do in order to improve the situation. So in a way it's a bridge between the two things. For people with mental health issues, I think this is a very important bridge. Service User

[the IAPT] *made me calmer because that was one of my big stresses and because that stress isn't there, it's freed me up to think about how I want to move forward in the future. I*

suppose I'll be more determined to do it. Service User

[the IAPT] *helped me with the counselling side to get back on track…once you get that little bit of help to get going again you're better out there instead of just being isolated.* Service User

I think the thing that's helped me most is the [IPS] *employment advisors…what was tending to happen was I would go into employment and I'd be ok to start with and then as you get into your job and the pressure grows and they expect more form you as an employee…you don't cope very well…It just leads to a long slide back down to where you were before and this was what was worrying me about going into employment again.* Service User

The value of the IPS and IAPT service to service users, providers, managers and JCP ESA Work Coaches was made very clear. This was undoubtedly a popular intervention.

3.1.2 What is the most effective form of the intervention?

What parts of the intervention were effective/less effective?

Qualitative analysis of data collected across the different participant groups allowed us to identify two key elements which characterised the pilot. These were: 1. the focus on and requirement for partnership working, and 2. the premise of providing employment support outside of the Jobcentre environment. How effective (or ineffective) these elements were in practice are discussed in detail below.

Partnership working

The importance of partnership working for this pilot came across strongly in the interviews with the service managers and employment specialists.

The pilot proposed to deliver psychological therapy and employment support in parallel, with the IAPT and IPS services working together in a coordinated and complementary way. Generally speaking this was seen positively – with IAPT and IPS providers seeing the value of each others services, how they could benefit each other, and what working together could achieve.

…lots of people coming through to us really need that IAPT support…for example people with severe anxiety…to have the IAPT worker working alongside and to be complementing… that journey back into work, I think does make a big difference. Service Manager

It's a good thing for the therapists…that they've got somewhere positive to refer them to because they aren't really clued up on the employment side of things…it's very, very bleak round here for support in mental health back into employment. Employment Specialist.

…the potential is massive and it links in perfectly. You can't get a better link than…IAPT and the employment coach and certainly with the Jobcentre. Employment Specialist

Some sites had IPS and IAPT services physically located together (co-located) with a shared manager. Others had to find different ways of working together, for example, placing IPS team members in IAPT services for short-periods.

It was very, very valuable having people spend a regular portion of the week within the [IAPT] *team, getting to know the team.* Service Manager

Though partnership working might have been facilitated by these factors, not being co-located and not sharing managers did not appear to be a barrier to success where there was buy-in from the services and both parties were committed to working together, and saw the benefits of what each other does.

I've got quite a good relationship with [IAPT service]. *If there are any problems with referral forms and stuff, I just call them up and if I've got any queries about anything. We just tend to speak on the phone, and we have regular meetings once a month or whatever*. Employment Specialist

I think [the IAPT] totally do get it…. it's very much with employment being the outcome for them as well. We all know as professionals, we all know the benefits of work. Employment Specialist

A number of factors were identified as reducing the effectiveness of partnership working, and in particular the provision of parallel support. The opportunity for IAPT and IPS to demonstrate parallel working was somewhat limited. This was mainly due to the delays in service users receiving support from IAPT, due to pre-existing waiting lists. Though triage usually occurred within a few days (or weeks depending on site), the waiting times for low intensity therapy could be up to 12 weeks, while wait for higher intensity or face to face support was often much higher (in one site up to 6 months).

…the idea…was that there would be two parallel forms of support for a group of people which hasn't happened in the majority of cases because of the constraints with the existing IAPT waiting times. Service Manager

IPS provision was able to commence after the service users had been triaged by IAPT, rather than services users having to wait until IAPT was able to commence. However, many service users preferred to wait for until IAPT had been commenced or completed before starting with the IPS service. This meant that often services were not provided in parallel, and IPS and IAPT services only having a few joint clients (particularly at the towards the start of pilot), causing some confusion for the IAPT providers.

[Being located together] *didn't work as well on the pilot because the response to begin with from the IAPT teams was "what are you doing here?", because we didn't have any joint clients*. Service Manager

This was despite IPS services making efforts to coordinate their work, and pace of work, with

the IAPT provision.

…they do a telephone assessment straight away and it's after that the delay seems to kick in…that does impact on obviously how we work with clients…because we can either speed up or slow down depending on where they are in their treatment. Employment Specialist

The delay in access to IAPT within the pilot was raised as a concern by all groups of research participants. Nine out of the twelve of the service user participants interviewed were still on a waiting list for IAPT when the interview took place.

I still haven't seen anyone yet, they put me through to the doctor's counselling to try that first…It's been a few months now but there's only one counsellor at my doctor's so I'm on their waiting list. Service User

Unfortunately the first bit [IAPT] *didn't work out because I was waiting for quite a long time.* Service User

JCP ESA Work Coaches also raised this as a concern, particularly in regards to the impact of the delay on client wellbeing.

IAPT needs to start quickly – not 9 weeks into a 6 month PILOT, too much valuable time lost with the customer feeling isolated. JCP ESA Work Coach

From information received I'd expected customers to get support from both IPS & IAPT at the same time. Unfortunately it turned out that the IAPT side has been a slower service for participants to get involved….. I've seen a lady today [November] *who was referred in September, she has been assessed in the last few weeks as needing 1-2-1 support but been told the waiting list could be another 15 weeks.* JCP ESA Work Coach

Service user wellbeing was a considerable concern. As noted above, many service users stated that they wanted therapeutic support to improve their health and wellbeing before feeling they were ready to engage with the employment support.

I think we would get the majority [of clients] *…middle towards the end of therapy…we will see people who come from triage and we think they need to have their therapy first, they're not ready. Motivation fluctuates, they've got lots of issues around managing their mental health.* Employment Specialist

I've had some say…I need IAPT first, I want to get this sorted before I can consider employment and when you mention the waiting…that does have a bit of a negative effect…because it's six weeks. Employment Specialist

JCP ESA Work Coaches emphasised how without the strong focus on IAPT in this pilot, it may seem to service users as though IPS was just another employment course, rather than part of a programme which also sought to support health needs.

I suggest that IAPT comes before IPS, otherwise it just appears to be another 'employability' course with a waiting list for therapy. JCP ESA Work Coach

In this customer's circumstances she feels support through IAPT was a key part of participating and needs therapy support before being ready to return to work. The pilot locally seems to focus on the IPS side. This customer felt she was applying for jobs she was not ready to take and this was an added pressure to her. If rolled out then surely the two services would need to work in tandem to support the customer's recovery and move towards employment. JCP ESA Work Coach

Interestingly, despite the clear commitment to IAPT as part of the programme from service providers and JCP, in a number of examples, the IAPT element was felt to be less necessary than had at first been anticipated. A number of clients achieved paid employment without having engaged with the IAPT element. Some of these were waiting for IAPT provision to begin, while others had been found ineligible for IAPT or did not engage with them (and therefore their case was closed by IAPT) but continued to work with the IPS service.

As noted above, the majority of service user participants interviewed had not received any IAPT support at the time of interview. A number of these reported that they actually had not wanted, or no longer wanted the IAPT component, either out of disinterest or because they had not found it helpful previously.

I had a stroke 8 years ago and after it happened, I was very confused…and at that point I wanted somebody to talk to about it. Of course it's 8 years later and I found that actually talking about it wasn't really helping me any more. Service User

I'm not 100% sure how I feel because I'm still having my ups and downs so I'm not sure if it's [IAPT] *really what I need, I don't know what else there is to do I suppose.* Service User

The design of the pilot with IAPT as the primary service, while IPS was only available as an optional add on (IAPT *plus* IPS) was identified as a problem for those participants who did not want to undergo therapy but wanted employment support.

It would be helpful if I could have a choice… the guys who were there turned round to me and said "well that will be the end of the programme, you'll have to come out of the programme if you don't have [the therapy]", so I don't even have a choice, I have to go… …. I don't need [IAPT]*, I've done all that stuff before and it never helped me and I feel like I've been forced onto the* [IAPT] *thing…I just don't think it's fair to be honest.* Service User

One client, who found a job through IPS while on the waiting list for IAPT, felt that finding a job displaced his need for therapy and meant he was no longer bothered by the delay in access to therapy.

So because of that [finding a job via IPS], *I'm not quite so cross about it* [the delay to IAPT]

but I think if that hadn't been the case then I might have been phoning them up and saying hang on a minute, what's going on? Because there is a phone number on the letter but I haven't chased it up because I actually feel at this moment that I don't need them because I feel, I'm waiting to start and I feel excited, nervous but excited. Like a kid waiting for Christmas. Service User

In general, it was felt that IAPT was less engaged in pilot delivery than IPS and JCP. It was suggested that for IAPT providers, participation was 'business as usual' and there was limited external effort to encourage IAPT's engagement with or participation in the pilot itself.

It's always felt like IAPT haven't really been part of it, they've taken the referrals because that's what they do and that's no different to them….. I think from sitting in on their team meetings, and hearing what they've had to say about it, that there's 101 different pilots they're asked to be involved in. So it's just another pilot – but I don't feel there's been much buy in as such from IAPT…. I've never kind of got my head around who was responsible for communicating with IAPT. Service Manager

In some cases it was suggested that IAPT might not be clear of the role of the IPS service, and were not necessarily fully aware of the benefits that employment support can bring to their clients.

Once a therapist has referred a patient and they've had that experience then they usually have it in their mind that if they get an appropriate patient, they can refer. But the therapists that haven't ever referred a patient, they don't think about them…When I say to them have you thought of employment support, they're like, oh, what a great idea. Service Manager

IPS providers found the partnership with Jobcentre Plus (JCP) to be crucial – something which was perhaps underestimated at the start of the pilot. The JCP was the pathway for clients to access the pilot. The knowledge and understanding of the JCP ESA Work Coaches about the pilot and about IAPT and IPS services, as well as their trust in what was being provided, were paramount to the success of referrals.

I think having the partnership with the Jobcentre, I think that has been really good. From an [employment service name] *perspective that has been a really positive experience and regardless of what happens with the pilot, I would want us to carry on that working relationship.* Service Manager

Jobcentre Plus has been more of an involved partner than IAPT. Service Manager

JCP ESA Work Coaches reported that relationships with IPS and IAPT service providers were improved by the pilot. The proportion of survey respondents who felt they had a good relationship with service providers increased from 33 per cent prior to the pilot, to 60 per cent during the pilot.

We had not worked with [IPS service name] *prior to the pilot so had no relationship with*

them. The employment coaches are regularly in the office and this has helped to build a positive relationship. JCP ESA Work Coach

Engagement with JCP partners was however a weak point in many instances, particularly early on in the pilot. While 93 per cent of JCP ESA Work Coach respondents felt they understood the pilot, only three quarters felt they were given sufficient information. This was particularly so at the start of the pilot, where 1 in 5 (21 per cent) did not feel they were given sufficient information.

More local contact once set up and running. An understanding of how both our organisations work to get better relationships with the people actually involved in running the Pilot not the management. JCP ESA Work Coach

Written comments from JCP ESA Work Coaches showed considerable variation in the extent to which the project was communicated to them, and how much of an attempt was made by service providers to engage with them and work with them as partners. While some individual Work Coaches were actively engaged, discussing the pilot with managers and colleagues and meeting with the local service providers, others just received an email (or multiple emails) from managers or district managers. How well individuals were engaged was suggested to have had implications for referrals, as discussed later.

Just over half (56 per cent) of JCP ESA Work Coach respondents felt the pilot was well-coordinated between the JCP and the service providers. In some cases JCPs felt that they had been excluded from the process. In particular some highlighted that there was no feedback loop, meaning they did not know what had happened with the clients they had referred. This reduced their confidence in the pilot and their ability to refer appropriate clients.

I have been disappointed by the way this pilot was run. We had some information at the start but felt let down quite early on when most customers we referred were either declined for the IAPT part or told there was a long waiting list. Customers were told they could not access IAPT before we were told, but feedback has not been given as to why someone could not access the IAPT part. JCP ESA Work Coach

As noted above, there was broad support among Work Coach respondents for the pilot. However one raised concerns about the partnership between JCP and the IAPT service, fearing that JCP referring to IAPT might give the impression that attending therapy was linked to benefits, and consequently reduce the value of providing access to treatment.

Don't do it. Expand the [IAPT service] *to cover all areas, but leave it as an NHS service to which we can signpost JCP clients. Don't try to make it a jobcentre provision, because that turns it from something supportive to manage their health (and move them towards work), into something just to get them off benefit.* JCP ESA Work Coach

Such concern did not appear to be very widely felt – only 19 per cent of JCPs thought that

concern over loss of benefits was an important factor in why clients participate (discussed further below). In contrast, a Work Coach from the same site thought that, although they usually provided clients with information on the IAPT service for them to self-refer, IAPT having a more formal link to the JCP could be a positive thing.

I am a regular user of this [IAPT] service. However, I usually give the customer the information to do a voluntary referral and felt that it would help more customers to engage if it were part of the JCP process. JCP ESA Work Coach

Employment support outside of the restraints of the Jobcentre

The provision of employment support outside of the Jobcentre Plus was also seen as an effective element of the pilot – highlighted by employment specialists, service managers, JCP ESA Work Coaches, as well as by service users themselves.

And because one of the scariest things is the…because [the Jobcentre] *pressure you a great deal to get back into work…because they have so many things that they expect you to do, you're expected to apply for so many jobs or do so much on the internet and all that sort of thing, which would be scary enough for me anyway because I'm not very good on the internet. But to try and do that and cope with expectations with the way my head is at the moment I just wouldn't be able to do it. So the employment advisor, they're mediating between myself and the Jobcentre.* Service User

Generally service user participants were very satisfied with the employment support they received. They reported appreciating the prompt, timely contact.

The employment people were very prompt actually and they got in touch with me within a week or so of them suggesting would I like them to put my name forward. So they were quite prompt with that as well. So I was set on my way quite quickly which was good for me because I was in a bad place and I needed some help. Service User

Flexibility was also frequently mentioned, particularly in terms of meeting times and locations, with the opportunity for them to be held in less formal locations (e.g. cafes) or even over the phone, depending on client preference.

Because of the kids I can't always make the appointments. So she's been very flexible and…appointments as well just to keep on top of everything. Service User

I think being able to meet people out in the community as well…because the jobcentre environment really doesn't suit a lot of people and it can be very intimidating and off-putting. Service Manager

This person-centred approach was repeatedly noted as positive – with service users highlighting the importance of the support being centred around their interest as an individual. Employment specialists were praised as being good listeners and having deep

conceptual understanding of mental health conditions, and commended for their ability to identify service user needs and provide appropriate support and advice.

They understand people's disabilities more because they've been trained in that field. Service User

...they know exactly how to help you and what help you need and what level and things like that. Service User

Employment specialists were felt by service users to have a high level understanding of what type of job would be appropriate for the individual job-seekers.

He could see what I was looking for. And he sort of got ideas in his head of jobs that would suit what I was looking for. It's almost like he had a list of jobs in his head, I don't know, as I was talking you could almost hear the cogs working as he put me and the job together. Service User

She encouraged me to look at things that interest me and for example I did some reviews of books that I've enjoyed. She's helped me with a CV and she's also given me ideas of jobs that would suit me once I've got my therapeutic assessment out of the way. Service User

It was this understanding of individual service user's needs and consequent individual approach that was seen as setting the service apart from other employment services.

Yes, it's a very good scheme, it's much better than the ones where you get pressurised and they send you to loads of jobs and they're like miles away anyway. And then the jobs they send you are things that you wouldn't even be able to do anyway…. this is much better, it's more tailored to people like me. Service User

A contributing factor to the ability of IPS employment specialists to provide such a service might be the fact that outside the pressurised Jobcentre environment there is more time to listen and to provide more general everyday support to people – allowing service users the opportunity to discuss a range of concerns which could be indirectly affecting their ability to engage in work.

I found they are there to help you, if I have any worries I could phone them and it's not too much, no trouble for them to talk to you. If they're busy and they say they will phone you back, and I've had so much support with them since I started. I know it's only been such a short time that I've been with them but I'm actually happy to phone…I feel comfortable. Service User

People listen and they care. I can have a bad day and turn up…this has happened, she can let me get it off my chest before we carry on…I'm…a person and I'm allowed to have feelings. Service User

The ability of the employment specialist to take a step by step approach to job search and be flexible about what sort of support was provided was valued. Clients for example discussed the importance of time taken to provide support with CV writing and how to navigate an online job search or online application – especially valuable for those who have been out of work for some years.

She helps me with the application forms because sometimes they're quite hard to fill in on the internet. Service User

…they've also helped me to enrol online which I find quite difficult because my concentration is not very good. Service User

…signposting information – like doing research for things that are maybe obstacles and coming back and saying I found this and this. Service User

Service user participants seemed to feel altogether that employment specialists were able to take a more gentle, less prescriptive approach with them, outside of the Jobcentre environment.

…it wasn't me being forced into anything. It was just talking about some things I might be able to do…so that's what took some of the pressure away from me because I get flustered easily. Service User

An important element of the employment support provided by IPS mentioned by service users was the knowledge that they would be able to work with the employer, and that there would be access to continuing support. Service users reported that just knowing that support was there if needed was important when starting a new job.

…they can come and speak to your employer…because it's very embarrassing to be in a situation where people expect you, because you look ok, they expect to be able to give you a job to do and you just go away and do it…So just to have them to fall back on, just even briefly I would think, once I get back into work I feel as though things would run much more smoothly. Service User

I do feel as though I would have someone that I could phone if I needed any advice or anything, it really took the pressure off a great deal. I can't tell you how much it's helped me actually…. I didn't know where to go and the doctors just don't have that expertise or like I say, the time to stand with you to try and address the situation. So I just can't say enough how much help it's been. Service User

What were the operational challenges?

In terms of the way the pilot sites operated, the key challenge identified was the difficulty in appropriately preparing for the project given the short lead-in time. A further factor was the amount of time required of managers to run the project, and manage the administration, over and above their usual duties. These are discussed briefly below.

The speed at which the pilot was set up and commenced caused a number of operational challenges for the sites involved. Recruitment of staff had to be swift which meant that some of the sites had to bypass their normal recruitment processes as they were too lengthy and they would not have had staff in post until half way through the pilot.

…I think we had two weeks to recruit and start getting some new staff. So we had to go down the route of using agency staff because being part of the council it takes months to get someone in post. Service Manager

It would take about 3 months to recruit staff [through the Trust]. Service Manager

In the case of Site C, where an employment service from set up from scratch, recruitment did not occur until after the pilot had commenced, putting them at a significant disadvantage given the short timescales available to deliver the pilot.

Getting staff up to speed with the role requirements (in particular understanding IPS) was a challenge for some sites, especially where staff had limited background in IPS employment support.

I have had to provide more support than I thought I would have to do initially…In six months you need somebody who gets it pretty much straight away. Service Manager

Limited set-up time also had implications for the ability to engage with partner services (as discussed above). In some cases this had considerable consequences for the pilot, for example, JCPs reported having insufficient warning before referrals were expected of them, and insufficient knowledge of the pilot, impacting on their ability to make referrals (discussed further below).

I feel that at first there was a lot of confusion with the referral process, it is a shame that now we are more confident with that process that it is coming to an end. JCP ESA Work Coach

I do not have my training until next week so do not feel very confident at the moment, but I am sure that my skills will develop. JCP ESA Work Coach

As very different scenarios were happening within the same pilot area it was not clear how much this was to do with the speed of set up, how much it was to do with the relationships between the IPS and IAPT services and the different JCPs, and how much it was to do with internal JCP communication. Comments provided by two Work Coaches associated with the same pilot site exemplify the difference in how the pilot was communicated to different people.

From my line manager via the internal email system and also by case conferencing with manager and peers. JCP ESA Work Coach

Received an email 20/6/14 stating PILOT to commence 23/6/14. JCP ESA Work Coach

Insufficient time to plan and prepare, and lack of knowledge about the likelihood of referrals coming through, meant that despite being rushed into place, once the pilot commenced, employment specialists often had little to do while they waited for referrals to start coming in. Service Managers on the other hand found themselves investing a significant amount of time in the pilot, from the beginning to the end. Most of them had to re-prioritise or reduce other areas of work in order to invest the time required.

I used to have a caseload and then for the duration of the pilot I haven't had a caseload to free up the time. Service Manager

I work 26.5 hours a week so I'm probably doing a good 22-23 hours a week on the pilot. Service Manager

Administration and management of data for the pilot (and particularly the evaluation) also presented operational challenges. These are discussed in section 3.1.3.

How could the interventions be improved for a larger scale trialling programme?

Service Managers and Employment Specialists were asked how the pilot could be improved for larger scale trialling. The length of the pilot and the amount of lead-in time were highlighted by all those interviewed as where the most improvements could be made in larger scale trialling. These are discussed briefly below.

Having more lead-in time to set up and promote the pilot was seen as improving the ability to promote the services, to develop good quality partnerships between services and to develop processes and communication channels which would ensure all stakeholders knew what was happening.

…I feel that had we had the benefit of a longer lead-in time, we could have perhaps… ironed out a lot of the things that had to be done as we went along. Service Manager

…you need to sell it, promote it…two or three month maybe to just promote it, get the routine in…we didn't have that preparation time, so we spent the first one or two months running around. Employment Specialist

More time for the pilot to run was also emphasised by the majority of interviewees. Six months was not thought to be long enough for this particular pilot.

The pilot is only for six months which is far too short a time to even begin to set up an IPS service let alone to embed it. Service Manager

Up until last week we only had 12 referrals…on to IAPT. It's a real shame because the project is going to finish before we've actually got the outcome of all the referrals. Service Manager

The short-time frame was thought to be an impediment to:

- *getting in referrals*, given the eligibility criteria and the need to build relationships with JCP;
- *delivering support*, particularly in terms of parallel support with IAPT;
- *building relationships with local employers*, especially for new IPS services; and,
- *achieving employment outcomes*, and allowing sufficient time for service users to experience the provision.

There were also some practical concerns around employing employment specialists for such a short period of time, as well as some ethical concerns around potentially leaving service users without support when the pilot ended.

Twelve months was seen as a more realistic length for a future pilot, including time to set up services and partnerships. This would also need to include an appropriate amount of time to recruit and train employment specialists. A longer pilot period might also allow time for IAPT and IPS to be delivered in parallel (given the IAPT waiting lists) and to allow the full IPS model to be delivered i.e. with in-work support offered once people found work.

I think longer term would allow you to properly build up those relationships in the community, which is a key part of IPS…. …. So the support once they're in work is almost as key as helping them get into work. Service Manager

As a pilot…ideally it would be 12 months because it can take up to two to three months from self-referrals to get into IAPT. So you're going to want a good chance of having two to three months after that working alongside them both. Employment Specialist

The delay in accessing IAPT services was found across pilot sites. Along with having a longer pilot to allow IAPT and IPS time to sync, suggestions included that additional funding be given to IAPT for the purposes of the pilot.

…I think if we'd had money for say an additional therapist…they could have been working with these clients a lot quicker…if there was a future pilot there would have to be something around additional money for therapists. Employment Specialist

…maybe they could have looked at using some of the money to fund specifically therapists to work on the pilot so that there was a quicker access to that route. Employment Specialist

From the JCP ESA Work Coaches perspective, the main concerns for a larger scale implementation were around improving their engagement, particularly in determining processes, and more generally in seeking their buy-in, as well as ensuring the parallel delivery of IPS and IAPT services.

Various things need ironing out. But overall, I think it is a good idea and worth pursuing – but

please ask the ESA advisers for more input if it is going to involve us. JCP ESA Work Coach

I only feel people would benefit from this Pilot if things improve, I would be put off referring unless this happens. The IPS should be delivered either with or after IAPT if the person needs this element. We also need more feedback from the providers locally. JCP ESA Work Coach

Better ongoing communication between the three partners was clearly sought. A specific point noted by JCP, was whether there was scope for two-way feedback channels, allowing JCP ESA Work Coaches to be informed about the progress of their clients. This was noted as being particularly helpful where a client had had difficulty setting up the initial appointment, or the individual was found to be ineligible for IAPT, or conversely informing services when a customer had had their Workplace Capability Assessment (WCA) and moved JCP claimant groups.

There was and still appears to be no clear system for marking LMS with 'started' 'not engaged' etc and referring the case back to the ESA adviser to refer to Work Programme or Work Related Activity etc when IAPT engagement has not been relevant. JCP ESA Work Coach

No clear system for advising IAPT staff when a customer has been put in the Support group or failed WCA and had to claim JSA, between my referral and IAPT seeing the customer (three such customers of mine). JCP ESA Work Coach

For JCP ESA Work Coaches, another major recommendation was that a larger scale trial might consider having wider eligibility criteria, allowing a wider range of clients to access IPS in IAPT support. Suggestions included allowing JSA JCP clients and ESA JCP clients with a longer prognosis (2 years) to participate.

JSA customers in our district would benefit as this would enable them to gain support and guidance during their work search journey and would result in better retention. JCP ESA Work Coach

3.1.3 What is the most effective delivery model?

What worked well/didn't work well during the referral process and why?

With four different pilot sites, and services provided by a partnership of organisations which was organised differently across the sites, there was inevitably some variation between the ways various aspects were managed. This included how the referral process was handled. At Site A the IPS service worked with three separate IAPT providers and very regular contact between the IPS and IAPT staff was challenged by limited time to set up the service and having the largest number of provider staff to bring together. Site B was able to integrate very effectively as the IAPT service was the smallest and a large team base made physical co-location of most IPS and IAPT staff easier. Site C had IPS and IAPT staff dispersed at office bases spread across a less densely populated county, but it was one single

organisation employing both IPS and IAPT, At Site D the separate IPS organisation worked with a single IAPT managing organisation split into two provider teams, again in a rural environment where the teams were dispersed. All sites had some difficulties with referrals whether it was the pace of referrals into the pilot when it began, the total number of referrals they received, the appropriateness of referrals made, the speed with which referrals into the services were managed, or the clarity of the referral pathway. Some sites had greater success with referrals throughout the course of the pilot than others (referral numbers are provided in 3.2). As the gateway into the IPS in IAPT service, the relationship with and the engagement with JCP ESA Work Coaches was crucial to how well referrals worked.

Identifying eligible clients

Several of the sites experienced a slow start in terms of the pace of the referrals into the service.

[When] *the pilot started it was a bit slow but I think most of us just wanted to get on with it. But the referrals were slow getting in really.* Employment Specialist

Delays in the processing of Work Capability Assessments (WCA) were mentioned by some sites as an issue, particularly at the start of the pilot. Some JCPs struggled to identify clients from their existing caseload, while others may not have understood that the pilot was not only for newly assessed clients.

Work capability assessments weren't going through, they had come to a halt…referrals weren't coming through as quickly as we would have liked. Service Manager

It was a good idea, we just did not have the numbers to refer to it. JCP ESA Work Coach

It's to do with the ones that are going for medicals, there's a huge waiting list at the moment…so they're dependent on those coming back from the assessment before they can actually have the opportunity to refer them to ourselves. Employment Specialist

Some sites were understood to be running other pilots aimed at claimants in the same group of JCP clients at the same time, which Work Coaches said limited the numbers of appropriate clients they were able to referred to this pilot.

At the time of the pilot there was another pilot being conducted which had an impact on referrals as it was targeting the same group of JCP clients. This was mandatory for JCP clients to attend. JCP ESA Work Coach

More generally the limitations of the eligibility criteria were identified as a barrier to referrals. This was seen in particular as being due to the need at first for a mental health condition to be the primary condition. Two months into the pilot, this was expanded to allow any client with a mental health condition to be included, regardless of whether this was listed as the primary reason for claiming benefit. This was identified as making identifying candidates

easier.

Eligibility was very specific in early stages and I feel there would have been more referrals if more relaxed criteria. JCP ESA Work Coach

To begin with the criteria were quite narrow and then we managed to get them extended because we just weren't getting referrals…originally it was …the mental health had to be listed as the primary condition so if someone for example…had had a car crash…then had associated mental health issues, couldn't come through. Service Manager

Appropriateness of referrals

All pilot sites received a number of inappropriate referrals from the JCPs. The majority were found to be unsuitable for IAPT due to already receiving a therapeutic intervention, or their mental health condition being too severe.

…a lot of them weren't really that suitable, good for the therapy but not for the employment support…too anxious, too depressed to even think about work. Employment Specialist

…we were having referrals coming through from the jobcentre…but then we found quite a few of them…weren't suitable for the pilot through different reason from the criteria.…they were already in secondary care…or they weren't eligible for the IAPT support, or they were already receiving IAPT treatment. Employment Specialist

I think I was referring inappropriate customers i.e. the hard to help with additional problems, e.g. personality disorder and alcoholism. It was not until I met one of the [IPS providers] *that I realised this.* JCP ESA Work Coach

To a large extent, inappropriate referrals were seen as being due to insufficient information being provided to JCP ESA Work Coaches.

The type of customers relevant for referral was not clear and has since proved to be the case when IAPT have seen the person and decided not to engage. JCP ESA Work Coach

When the Pilot started there were mixed messages as to who was suitable to be referred as I was confused over the definition of mental health, so think I wrongly referred JCP clients. JCP ESA Work Coach

Many JCP ESA Work Coach respondents acknowledged they had made incorrect referrals at first, but had improved as they learnt more about the project in time. Unfortunately given the length of the pilot referrals had to stop on the 31st October, four months into the pilot, meaning an initial delay in understanding might have had considerable implications for referral numbers.

The complexity of the pilot and the multiple services involved was indicated to have had an

impact on referrals – thought be confusing for both clients and JCP referrers.

Some clients when they come to meet with [IPS service] w*orkers, they think they're coming to meet with a therapist. So I think it's very confusing for the clients and I can understand why. IAPT and IPS sound very similar, it's quite jargon-y isn't it? So this bit is optional but if you want this bit you have to do this bit but you don't have to do this bit…and I think it's an awful lot for them to digest. So its felt quite complicated the referral process.* Service Manager

It's a big service, it's a lot to take on board and it took me a while to figure out what actually goes on from when I started…you just need to understand what each person's role is. Employment Specialist

The presence of pre-existing employment service at some pilot sites, with a less restrictive eligibility criteria, was also identified as a possible point of confusion in terms of making referrals.

Clear processes

Having a clear process and communicating it well was identified as crucial to improving referrals. Site A had the highest numbers of referrals. Box 2 provides a description of their referral process. The process was supported by developing a factsheet and a referral flow chart from distribution to stakeholders

Site A's process was used as a model for the other sites, who adapted it to their own sites needs. In Site A, the IPS employment service rather than IAPT was the central point of contact. This differed between sites, depending on how they were set up, i.e. whether they were co-located and/or whether the IPS service existed prior to the pilot.

Box 2: Sample referral process for Site A

1. Jobcentre referral to agreed single point of contact (in this case, in the employment service).
2. Employment service calls client within 24 hours for triage.
3. Ascertains needs and which service they are interested in (IPS, IAPT or both).
4. Employment service sends client the IAPT form (for self-referral).
5. Employment service sets up initial meeting with employment specialist.
6. Employment specialist meets client.
7. Client returns IAPT form to employment specialist.
8. IAPT form forwarded to IAPT.

Some sites made the suggestion that it would be better if the initial single point of contact was in the IAPT rather than the IPS service.

…it would be much easier if the referrals came from people who had already self-referred IAPT because from the IAPT services' point of view, the people coming through on the pilot are no different to anyone else, they're just people accessing their service through the normal route. So then if the workers…ask someone about their employment needs…That

would be a far better referral process. *Service* Manager

Others went on to question the role of JCP in this process, suggesting that JCP ESA Work Coaches might not have the enough information on clients to make appropriate referrals.

…if it's coming from IAPT route, the referral…then you know where they are in terms of mental health issues. Whereas in all fairness to the job coaches they're not as aware of the mental health issues…they don't have the information. Employment Specialist

Communication and engagement with the JCP

The information provided to JCP ESA Work Coaches and given to potential participants at the point of referral was not seen as adequate at all sites.

…one Jobcentre…basically said all they got was a leaflet. A leaflet on the Friday that it rolled out the Monday…but the leaflet didn't really explain anything. Employment Specialist

Poor communication and lack of knowledge about the pilot among JCP ESA Work Coaches reduced the ability of some to confidently make appropriate referrals. One third of survey respondents did not agree that they felt confident in explaining the pilot to clients. How well this worked appeared to vary considerably between sites and individual Work Coaches. While some spoke highly of the referral process, others struggled at first but were confident by the end, while for others confidence did not increase. This demonstrated the importance of having a clear referral processes and communicating it clearly.

There was further confusion over how it would actually work…. it certainly put me off referring JCP clients as was not confident in how I was selling it. If we had a meeting before it started I think I would have been more confident. JCP ESA Work Coach

I received conflicting information on key points including eligibility and support available. Whilst I appreciate that a Pilot is an opportunity to test and fine tune a process I feel that the message and claimant was lost. What would have been helpful to me was one source of information with a definitive flow chart detailing the end to end process. JCP ESA Work Coach

The speed with which referrals were made was noted as important, with Work Coaches wanting to feel that they were referring clients to something timely and appropriate.

I thought the referral process worked really well. Speaking to someone and getting the appointment booked straight away, takes some of the anxiety away from the customer as it was done in the interview. JCP ESA Work Coach

At the beginning there were long delays in customers being contacted. I referred someone on day one, and it took a month for her to get her first appointment. The referral process was straightforward, but often there was an answer message saying that referrals couldn't be

taken, and to leave a message. On leaving a message, I wasn't always called back, so had to phone again. JCP ESA Work Coach

Service user participants, selected from those who had remained with the IPS service and therefore might be assumed to have had a positive experience with the pilot, reported finding the referral process quick – having an appointment with the employment specialist within one to three weeks.

There were also many positive examples of what was seen to work well in generating referrals in terms of communicating and engaging with the JCP. As the pilot progressed, all pilot sites worked to improve the information provided to Jobcentres and ESA Work Coaches to allow them to better understand and communicate the pilot to potential service users. Examples of good practice included information sessions for potential service users, service providers spending time with JCP ESA Work Coaches to explain the pilot in more detail and the development of flowcharts and clearer information for both JCP staff and participants (Appendix C).

One of the most useful aspects identified was where the employment specialist was able to work with JCP staff, to demonstrate how the support works, and help identify who would be eligible.

Co-location of the employment specialist with the jobcentre staff is better so that we can actually get the referrals in and appropriate referrals. Service Manager

...the jobcentres…have enjoyed the presence of someone like myself in there. So we've actually done three way interviews which has worked really well…and if there are any issues I can actually go in and liaise with them. Employment Specialist

I have really enjoyed working with the employment specialists and have found this to be a really useful support mechanism for those with mental health conditions. Would really like the pilot to be extended or made permanent. JCP ESA Work Coach

IAPT referral process

A further issue in developing effective referral processes was the existing referral and access process of the IAPT service. In some cases, this appeared to create barriers to accessing the pilot. This was mainly focussed around the IAPTs strict 'DNA' (did not attend) policy wherein not attending two appointments or missing two attempts at contact without response resulted in the case being closed, thus meaning that the case should also be closed at the IPS service.

Two DNAs where if they can't get in touch or they don't contact the service to say yes I do still want to be in therapy, then they're discharged…and they can't work with us. Employment Specialist

The onus within IAPT being on pilot service users to self-refer was also identified as a barrier to participation, given the reliance of the individual to make phone calls or answer letters, possibly when unwell.

…they might self-refer but then have to respond to whatever…comes through the post and if they don't then they're automatically closed, depending on how good someone is at responding to letters. Service Manager

Several service user participants in sites where IPS and IAPT services were not co-located felt the employment service needed to have a stronger role in getting people access to the therapeutic support.

The [IPS service] people don't actually do anything towards it, all they do is make a phone call and then hand the phone to you. Some people that I know who have a similar condition to me, but worse, they would go to pieces in cases like that. I think that there should be more help in actually getting that mental health help. Service User

They kept saying like there would be good opportunities and nothing has actually happened, she said that we can go out to places and stuff like building your confidence up and everything, that's never happened…that's all they could say was opportunity and support…big words and that's all she kept on saying to me. Service User

Where clients had not successfully accessed IAPT services, this was not communicated back to JCPs, with clients having to let their Work Coaches know instead. This again highlights a potential gap in the referral pathway.

The first time…no one contacted me…so I went back down to the jobcentre and she phoned them back up and just said look, she's not heard anything. And then we sort of arranged for another person to call me. Service User

Administration and management of referrals

Ensuring that information was collected on referrals and that this was shared with both the IPS and IAPT elements of the service was complex. Depending on how the services were linked, and whether the single point of contact to which referrals were made was in IPS or IAPT, may mean different patient identifiers. Where the referral went to IPS first and there was no co-location, there might not be an easy way for IAPT to know that a service user who self-refers to them as part of the pilot, was in the pilot (unless notified by the individual themselves). In such a case, the IPS would need to contact the IAPT to check on referrals and ensure that this was being coordinated. Again partnership working was very important. This was further emphasised by the difficulty in sharing and collecting Management Information. The pro forma provided by the researchers required both IAPT and IPS services to provide information. Completion of the management information spreadsheet was difficult to coordinate, particularly where it involved sharing personal, de-identified data across two different services.

Some IPS sites designated an employee to oversee the referral processes, and ensure information was recorded. The relative capacity of the IPS and IAPT services meant this seemed to sit easier in the IPS. This individual was also crucial to developing good partnership links between the services.

Because we're going to be having to take into account all of the referral process, we knew that if we didn't have that position, the referrals coming through to us would be really patchy, we wouldn't have had the numbers of referrals we've got and we wouldn't have had that communication with the IAPT team. Because [point of contact] *calls the IAPT teams on a weekly basis to get an update on all the referrals she's sent through.* Service Manager

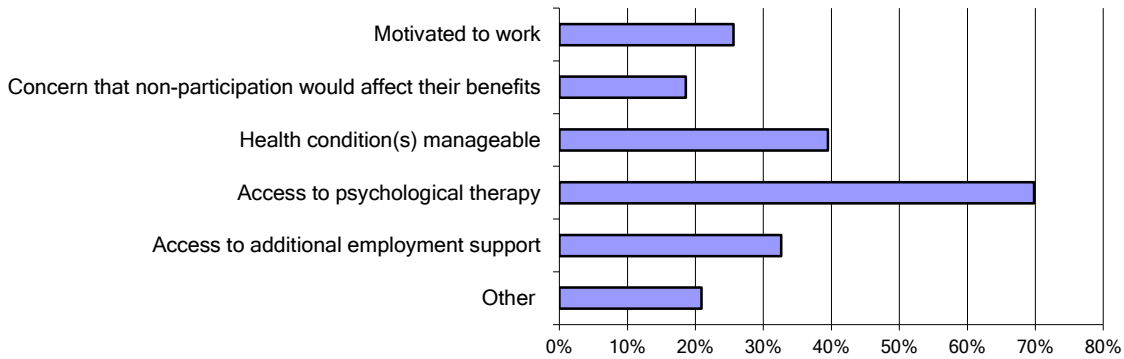
It was further noted that where IAPT was the first point of contact for service users, getting consent forms for the evaluation completed was more difficult, meaning that some participants had to be removed from the evaluation. Miscommunication at one site also meant that service providers thought consent for the evaluation was being collected by the JCP, while actually they were only collecting consent for participation in the pilot.

What are the drivers for clients participating/not participating?

Access to psychological therapy

Access to psychological therapy was one of the main reasons given by service users for their participation in the pilot. This was also reflected by JCP ESA Work Coach respondents, 70 per cent (n=30) of whom thought that a main reason that clients chose to participate in the pilot was to gain access to psychological therapy.

Figure 1.1 What do you think are the main reasons clients chose to participate in the pilot? (tick all that apply)



Many service users had hoped that they would receive treatment faster through the pilot, than through usual NHS provision; some had already been on IAPT waiting list for several months. In some cases it seemed that Work Coaches also thought that participation in the pilot would provide service users with prioritized access to IAPT services, and this may have been miscommunicated to participants.

It was never mentioned at the beginning of the pilot that the customers would be expected to discuss work. JCP ESA Work Coach

…for me, part of the reason for choosing that was that I get access to proper counselling which I wasn't getting access to successfully through the NHS. Service User

I was going in and out of the black periods a little bit more regularly and I felt that I needed to do something to try and combat this. So it felt to me like a quicker way of doing it than through the NHS. Service User

Psychological therapy was also found, to a lesser extent, to be a reason for client non-participation – with 42 per cent (n=18) of Work Coach respondents believing that *not* wanting psychological therapy was a reason that clients chose not to participate. The psychological therapy element presented a barrier in another way, in that many clients were already in treatment or had previously participated in therapy through IAPT and therefore did not want it through this pilot. This was problematic given the pilot requirement that IPS was an add on to IAPT. Therefore such individuals become ineligible for the pilot. Four out of five (79 per cent) of Work Coach respondents identified that people already undergoing treatment was a main reason for non-participation in the pilot.

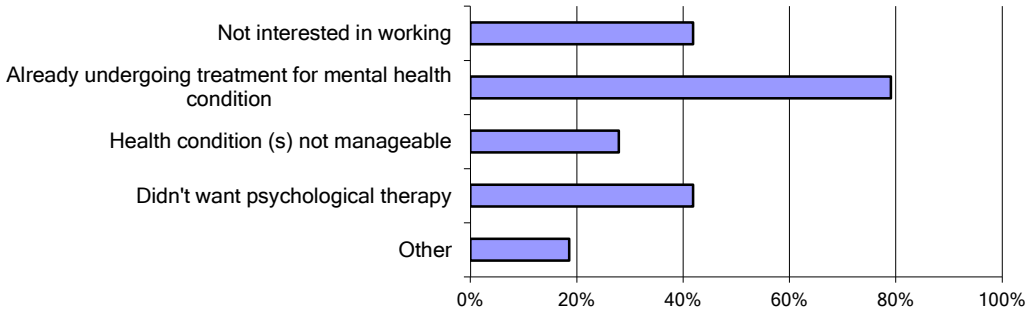
During interview with customers it was evident that a lot of them within the eligibility criteria had used the service before, working with them now or waiting for an appointment date as had been referred via GP. JCP ESA Work Coach

Many customers were already accessing mental health support from the IAPT provider so we could not refer them. I only referred one customer in the end. JCP ESA Work Coach

Access to employment support

Access to further employment support was another important reason for participation in the pilot. Some service users identified the need for further practical help on how to get back to working life, particularly where they had not been in work for several years. Service users reported that they hoped the service would help them to identify their strengths, and set career goals.

Figure 1.2 What do you think are the main reasons clients chose NOT to participate in the pilot? (tick all that apply)



…it sounded like a good scheme to help you get a job and it sounded like it wasn't under too much pressure, at some of the work schemes there's quite a lot of pressure. Service User

A quarter (26 per cent, n=11) of JCP ESA Work Coaches felt that one of the main reasons clients chose to participate was that they were motivated to work. Additional comments from Work Coaches identified that several saw the pilot as providing clients with an alternative to the Work Programme, which many of those eligible for this pilot were wary to undertake. A third of Work Coach respondents (n=14) thought that access to additional employment support was one of the main reasons clients chose to participate in the pilot. This was not identified across the eligible group, with 42 per cent of Work Coach respondents (n=18) feeling that a main reason for non-participation was that clients were not interested in working.

Service users interviewed reported wanting to go back to work for financial reasons, as well as due to wanting to participate in regular, meaningful activity.

It makes things worse because I worry about not being in work and having a wage coming in and it affects everything you know. Service User

I've been unemployed for a couple of years now and I felt that financially I could do with sort of getting back to work. Service User

Feeling compelled

There was concern from some employment specialists and service managers that some clients may have felt compelled to participate in the pilot due to the way in which it was explained to them at the Jobcentre. For example, due to a misconception that if they did not take part it would affect their benefit payments. This did not appear to be a concern at all sites, and could relate to the way individual JCP ESA Work Coaches explained the pilot.[6] This was seen as one of the reasons for clients disengaging from the pilot directly after referral.

…there is a sense that perhaps a proportion of the referrals have said yes because of who has asked them rather than because they want the support…it's the jobcentre that pays their benefits... Service Manager

…there are clients who have been seen who are using it just, not to be cynical, but to push along their benefits maybe. And they haven't really engaged properly or been fully into it. Employment Specialist

…we're finding that they're agreeing to it when they're face to face with the job coach but

[6] It is further noted that the pilot was in the media earlier in this year which may have influenced people's perceptions of it.

then not actually following it through. So not returning calls or not self referring into IAPT. Service Manager

Nineteen per cent (n=8) of JCP ESA Work Coach survey respondents, identified 'concern that non-participation would affect benefits' as one of the main reasons clients might choose to participate. This was the least common response. This was not generally reflected in JCP comments either, aside from one respondent (as noted above) who showed considerable concern that the direct association of therapy with the JCP might change JCP clients perspective of IAPT provision.

As soon as you put the Jobcentre's 'stamp' on it, & turn it into jobcentre provision, it has an immediate negative effect on the claimant's perception of the service. JCP ESA Work Coach

Manageability of health condition

Manageability of health condition may also have affected whether or not clients chose to participate in the pilot, with this being identified by 40 per cent (n=17) of JCP ESA Work Coach respondents as a main reason for participation, while 28 per cent (n=12) saw health not being manageable as a reason why people would not have chosen to participate (see figures 1.1 and 1.2). Employment specialists also reflected that an individual's health was an issue for some who had been referred to the service, who later found they were not ready to engage.

…one or two clients…have said they are quite severe and they've engaged, they came to the first appointment but because of their condition they've disengaged after. Employment Specialist

Information was also elicited on why participants may have dropped out of the pilot. As discussed above, from an IAPT perspective, not attending appointments or engaging with the service was a primary reason for drop out. Difficulties contacting participants was also a reason for loss of people from the IPS element of the pilot, as was a deterioration in wellbeing. Very few people appeared to withdraw from the IPS provision.

How has the support influenced the behaviour and attitudes of participants?

The support was directly linked to a number of tangible employment-related outcomes, shown by the Management Information data, including the outcomes of the JSSE (discussed in section 3.2). From a qualitative perspective, the most important way the pilot was seen to influence behaviour and attitudes of service users was in increasing their confidence to engage with and seek employment. This was noted by employment specialists and service users alike.

It's crazy how much confidence they do gain just by getting a CV. Employment Specialist

It's certainly increased confidence. Increased confidence with the long drawn out forms and things that you have to fill in now. Service User

Service users experienced a change in their belief about the likelihood that someone would employ them despite their health problem – allowing them to become more positive about possibility of working.

…they're quite surprised…someone is willing to employ them and that does give them a confidence boost. Employment specialist

It made me…think about the fact that maybe I can get a job…I was very worried that I would not be able to get a job because of the fact if I put down my medical history to somebody they would look at it and kind of laugh and say no. Service User

It's helped me realise that there's still a chance I can join the workforce again. Service User

It's really helped me to realise that I do have value in the workplace and they've helped me see the skills that I could take to employment. Whereas you feel quite sort of useless, they have looked at my employment history and we've talked about it and they've instilled some confidence in the fact that I do feel more able now, I've started with the volunteer service as that will help with my confidence and help me get back into a routine which is what I need…I feel as though I'm gonna be ready to go back to work much much sooner than before. Before it would have been maybe if not ever going back to work. Service User

The support was found to be highly motivational, for some service users it reignited both their interest in, and their drive to find work. Some noted this in contrast to what they were experiencing through the Jobcentre.

I think my motivation is definitely greater and it's definitely affected my confidence because I think that going to the jobcentre is demoralising. Service User

...you kind of find yourself thinking, I can't do that, I couldn't do that, and it just made me kind of – end up thinking that I was good at my old job. So I actually just went in and saw my old employer and…they found me a job. Service User

The boost in confidence and motivation was primarily attributed to the employment specialists' support and encouragement, pushing them to keep going and achieve their aspirations. This was underlined by the specific skills of the employment specialists in understanding what clients wanted and needed

I heard about this company and normally I have waited for them to get back to me but she [employment advisor] *gave me a push so I kept bugging them and I ended up with a job.* Service User

…if you haven't got the confidence to do things, you sort of sit back and then nothing gets

done. Whereas if you've got somebody there to support and say, it's ok, you can do this, it's alright, then it gives you more of a push really to go out and do things. Service User

…he came up with ideas that were exactly what I was looking for and that then relit the spark. Service User

The ability to access ongoing support once in work was noted as a particularly important aspect of IPS for maintaining confidence and emboldening service users.

He met me in the first…two days in my job and I was a complete mess and in a state then and he said look just do a week, see how you go. If you need me while you're at work just phone me and I will chat to you. And then by the end of the week I phoned him and just said I can't do this, it's not working, I can't seem to feel happy in this job. Right ok, come in and see me on Monday, so I came in on the Monday and had a chat with him and he's like no you did the right thing, you left, it needed to be done…And then I found another job so he's just keeping an eye on me just to see how I go. Service User

For those who have found work, the pilot influenced the behaviour and attitudes of service users considerably, with reports that it was life changing.

I've been really enjoying getting back into work…it's turned my life around. Service User

Variation across pilot sites and from specification

In this section we note the main ways in which the intervention varied across pilot sites, including where the pilot may have departed from the original specification. Much of this has been discussed above, but will be briefly reiterated here for clarity. Numbers of referrals and employment outcomes achieved by different sites are summarised in section 3.2.

Different operational models

Sites were set up in different ways. While some had separate IPS and IAPT services, others were co-located. One site had to set up a new IPS service for the pilot, though they had previously employed employment specialists as part of IAPT, primarily to support job retention.

Different referral processes and data collection

Sites had different processes for the referral of service users into the service, and between different elements of the service. This was to a large extent related to the way services were set up. Whether the single point of contact was in IAPT (via self-referral) or IPS was a key driver of this. This also affected the ability of service user data to be collected and managed across the sites.

Fidelity and centres of excellence

The quality of IPS services varied across sites. Two sites were pre-existing high fidelity services, and Centres of Excellence of IPS. One site was pre-existing but not a Centre of Excellence, while the fourth was a new service and therefore had not been assessed. Some variation in the way services were provided and how closely they ascribed to the fidelity principles was noted in the interviews with employment specialist and service managers across sites.

Different levels of partnership working and engagement

The extent of partnership working and the relationships between IPS and IAPT, and between the pilot service providers and JCP varied considerably. Whether IPS and IAPT services were co-located or not was clearly a considerable driver of partnership working, though efforts by IPS to engage IAPTs which were not co-located often proved fruitful.

While IAPT and JCP may have had pre-existing relationships (though not in all cases) with at least some awareness of the IAPT service, pre-existing IPS services were less likely to have this. Efforts to engage with JCP varied considerably across sites, with some having relatively little success, while others foresaw continuing to work together as a result of the pilot. Involving JCP earlier, were among the successful strategies used in some sites.

Given the short-time for the pilot, and the variation in how developed different IPS services were (e.g. how ell established they were prior to the pilot) it is not possible to say which model worked best. The highest numbers of employment outcomes were achieved from Sites A and Site D, both of whom had an existing IPS service, which had achieved Centre of Excellence status.

3.2 Analysis of Management Information

In this section we review the Management Information collected from service providers on service use and outcomes at the four pilot sites. This will provide an overview of service use, as well as seeking to specifically answer the research questions:

3. Did the measure have an impact on employment related outcomes?

4. Did the intervention have a measurable effect on the mental health-related outcomes?

This data includes a range of outcomes collected via four measures used across the four pilots – the GAD-7, PHQ-9, the WHO Five Well-being Index, and the Job Search Self-Efficacy (JSSE) scale. There are however a few caveats to the data collected during this pilot which need to be considered when comparing outcomes from this pilot to those attained through the other pilots. In general these relate to limitations caused by the nature of the interventions used in this pilot, and length of this pilot.

Firstly, ‘completion’ in terms of both IPS and IAPT are complex concepts. A principle of the IPS model is that support is ‘time unlimited’, and therefore completion is moveable. Though finding a job might be seen as the primary outcome, where someone finds employment the IPS model provides ongoing support for that individual and their employer. For those seeking jobs, support will also be ongoing. Many stages are identified as showing progress towards this primary outcome (i.e. closer to the labour market) such as completion of CV, writing applications and attending interviews. These are also seen as ‘outcomes’ of IPS.

As regards IAPT, different people will be assessed as requiring different levels of support – so while one participant might have six weeks of low intensity computerised support, another might have ten weeks of high intensity face to face therapy. A further issue is the waiting time for IAPT, and the requirements for IAPT to be provided in parallel to IPS. The time limit of the pilot meant that relatively few people were able to undertake the parallel service provision intended of the pilot. It also meant that relatively few people were able to ‘complete’ their therapy before the end of the pilot, and therefore collection of outcome data for the health measures (PHQ, GAD and WHO Wellbeing) was problematic. Consequently many participants were still undergoing or waiting for treatment when the pilot finished.

A further issue was the difficulty in getting IAPT providers to collect the additional data required in the form of the WHO Wellbeing measure. Collection of this data was low across the pilot sites. This was attributed to there being a large number of IAPT providers involved in the pilot sites (seven services made up of eight provider organisations) and difficulties in communicating this requirement to them – exacerbated by the short timescale of the pilot, and lack of clarity over who was responsible for engaging with IAPT. Along with poor awareness of who might be a pilot service user in some cases, service providers also suggested that some IAPT providers did not know they were supposed to collect this information.

It hasn’t been a battle, but it felt like they just didn’t know they had to do it. Service Manager

Providing data into the spreadsheet pro forma where services were not co-located proved problematic, not least as it involved sharing of personal information on service users. In many cases data is unclear or incomplete, particular from the IAPT side of the pilot. In addition, as noted above, issues around gaining consent for inclusion in the evaluation mean that some data had to be removed from the analysis.

There was also some difficulty gaining written consent for participation in the evaluation from some service users. Where written consent was not achieved, the service users details were not included in the evaluation, thus reducing numbers of service users for which we can

provide outcome information.[7]

3.2.1 Summary of MI data

The pilot originally aimed to achieve 250 referrals at each site to the IPS in IAPT pilot. Several of those referred to the pilot chose not to participate in the pilot after the initial referral, or chose not to undertake the IPS component (these participants were referred just to IAPT). Referrals and participation per site can be found in Table 1. Data was collected until referrals closed on 31st October 2014.

Table 1: Total referrals from JCP to the four sites (up to week ending 31/10/14) and pilot participation

	Total referrals	Declined IPS	Declined IPS and IAPT	Total participants
Site A	253	52	73	128
Site B	18	6	8	4
Site C	58	14	1	43
Site D	84	7	12	65
Total	**413**	**79**	**94**	**240**

Not all of the 240 people entered into the pilot made contact with either the IPS or the IAPT service. Several participants also chose not to participate in the evaluation. Collection of their data was then ceased, and any data previously collected was removed from the analysis and destroyed. In other cases data was collected until 15th December 2014. All the data used hereon includes only those who consented for their data to be included in the evaluation.

The total numbers of pilot participants who consented for their data to be included in the evaluation can be found in Table 2. These are the number of participants counted after removing those who had either a) withdrawn from the pilot (i.e. elected not to participate in the full pilot or in the IPS component as in table 1), or b) not consented to participate in the evaluation.

[7] It is noted that at one site consent for evaluation was sought after data collection had commenced. Though the site made every effort to contact service users retrospectively, those who could not be contacted or did not permit use of their data in evaluation at this stage were omitted from reporting, and any data collected was destroyed.

Table 2: Total participants in IPS in IAPT pilot evaluation (after removing those for we did not have a consent form for the evaluation)

	Total participants in evaluation
Site A	93
Site B	3
Site C	5
Site D	65
Total	**166**

Table 3 shows how service users (who consented to participate in the evaluation) used the IPS services at each site. Over one hundred IPS service users had over four hundred appointments with IPS employment specialists – an average of four appointments per person. 41 participants in the evaluation chose to access IAPT only and did not wish to accept IPS support.

Table 3: Use of IPS services (all sites) as at 15th December 2015 – participants in the evaluation

	No. of IPS service users	No. of appointments	Average no. of appointments per person
Site A	67	174	3
Site B	2	11	6
Site C	2	12	6
Site D	54	235	4
Total	**125**	**434**	**3**

Data collected using employment and health measures for those consenting to participate in the evaluation are provided in the following section.

3.2.2 Did the measure have an impact on employment related outcomes?

Data was specifically collected on employment-related outcomes for pilot service users. Though impact on benefits (particularly benefit off-flows) was highlighted by DWP and DH for monitoring, given the nature of the JCP claimant groups involved (for many of whom some work would have been permitted), benefit off-flow data was not seen as necessary. In addition, collecting such information would have added an extra layer of complexity to the pilot and its evaluation for little added benefit.

Data collection focussed on: employment outcomes (job achieved), employment-related outcomes (i.e. applications made and interviews attended) and change in Job Search Self-Efficacy (JSSE) score as measured by a nine question scale (complete scale is provided in Appendix B).

Table 4: Job-related outcomes (all sites) as at 15th December 2015

	No. of IPS service users making job applications	No. of applications *(average per person)*	No. of IPS service users attending interviews	No. of interviews *(average per person)*
Site A	15	33 (2)	7	9 (1)
Site B	2	2 (1)	0	0
Site C	1	1 (1)	1	1 (1)
Site D	25	147(6)	15	29 (2)
Total	**43**	**183 (4)**	**23**	**39 (2)**

As shown in table 4, on average, services users made four job applications during the pilot (range 0-42), and undertook two interviews (range 0-9).

Table 5: Paid job outcomes

	No. of IPS service users achieving paid employment	No. of paid job outcomes
Site A	6	6
Site B	0	0
Site C	0	0
Site D	9	10
Total	**15**	**16**

A shown in table 5, at 15th December 2014, a total of 15 service users had achieved paid work. There were however 16 paid job outcomes, as one participant achieved two different paid outcomes at different times during the pilot period. Most were on the waiting for IAPT services at the time of interview. Two had undergone IAPT (one if whom had completed), while two others were not on the waiting list for IAPT – one having been assessed as inappropriate, while the other had had IAPT previously.

The 15 people who gained a job during the pilot:

- Attended 74 IPS appointments, an average of 5 each (range 1-11);
- Made 82 job applications, an average of 5 each (range 0-42); and,
- Attended 26 job interviews, an average of 2 each (range, 0-9).

All IPS employment specialists were asked to complete the Job Search Self-Efficacy (JSSE) questionnaire with IPS service users at their first and last appointments. Only two sites returned both pre- and post JSSE scores (n=43). Despite low numbers, the average JSSE score clearly increased for those participating in the pilot. Average score is in Table 6.

Table 6: Job Search Self-Efficacy scores

	Avg JSSE score at start (range)	Avg JSSE score at end (range)	Change
Sites A & D	**24** (13-44)	**31** (15-45)	**+7**

Unsurprisingly, those who found employment experienced a considerable increase in Job

Search Self-Efficacy – rising from an average of 23.4 (n=14) to 33.7 (n=10).[8]

3.2.3 Did the intervention have a measurable effect on the mental health-related outcomes?

Evaluators were also asked to collect information on changes to the psychological state of service user participants. IAPT providers were asked to provide pre- and post data collected via their standard measures (GAD and PHQ), as well as collecting pre- and post data using another measure – the WHO Wellbeing measure.

As discussed above, completion of these measures was limited by the ability to 'complete' IAPT. However, looking at 'complete' scores for GAD and PHQ, there is a clear change despite limited numbers (n=10).

Table 7: Health and wellbeing scores (negative numbers show reduction in symptoms)

	GAD at start	GAD at end	GAD change	PHQ at start	PHQ at end	PHQ change
Average score	15	11.7	**-3.3**	18.2	14.9	**-3.3**

Nine of those who had an employment outcome had scores recorded for the start of GAD and PHQ. On average, their GAD score was 14.8, and PHQ 16.2 – slightly below the average for all service users. Only two service users had data recorded for 'end scores. This was substantially lower than their 'start' scores.

Unfortunately, complete data was not provided by any site for WHO wellbeing measure. Therefore no data on change in WHO Wellbeing score is included in this report.

[8] Not all participants achieving employment completed the post-pilot JSSE questionnaire.

Chapter 4 Conclusions and recommendations for a larger scale pilot

Across the different participant groups, and across the pilot sites, there was considerable positivity about the IPS and IAPT service, including those sites that did not already have a similar service in place. Fifteen service users found paid work, an achievement worth recognising given that their placement in the ESA WRAG with 12 months or higher prognosis indicates they were not anticipated to engage in work for at least 12 months. In addition, a range of other heath and employment-related outcomes were achieved, including increases in health and wellbeing scores and increases in job search self-efficacy, as well as more tangible outcomes such as applications made and interviews attended.

A number of limitations were identified during the evaluation that reduced the ability of the pilot to achieve higher numbers of participants and employment outcomes. There was considerable variation as to how well sites performed, with some sites struggling to get referrals, and high drop-out levels.

In the following section we will address some of the gaps and associated issues identified in this pilot, before making recommendations for how these could be addressed in a larger-scale pilot.

4.1 Conclusions

Low number of referrals: Lower numbers of referrals into the pilot were received than originally anticipated with considerable variation across pilot sites. The restrictive eligibility criteria for the pilot were identified as a key factor, with some sites experiencing considerable difficulty identifying suitable candidates (though eligibility criteria were widened during the course of the pilot). Although addressing the delays caused by Work Capability Assessments was outside of the remit of this pilot, they were suggested as one reason for why there was some difficulty in identifying suitable candidates. Some JCPs also reported that they did not have the capacity to review JCP clients on their existing caseload to identify eligible participants. The lack of lead-in and preparation time influenced referrals as many JCP ESA Work Coaches did not feel suitably briefed. Highest numbers of referrals were achieved in established IPS Centre of Excellence services, where the IPS service took a lead on referrals (as the single point of contact). This was seen as important where IAPT services may not have been as engaged with the pilot.

High numbers of drop-outs: Drop out rates for both IPS and for IAPT varied considerably between sites. The majority of those withdrawn from IPS was as a result of difficulties in contacting them. Reasons for this centre around the complications of administration caused by a pilot organised between three services. One such issue was that participants, despite agreeing at the time of their JCP interaction, later did not wish to be contacted as they were

not actually interested in the service at that time. Communication issues were also suggested (e.g. someone being uncomfortable being contacted on the phone or missing an appointment). Another reason given for drop out from IPS was deteriorated wellbeing, i.e. feeling too unwell to pursue job search.

For IAPT Clients *'did not engage with service/DNA'* was the most common reason. Similarly, this may have been due to client disinterest, or administration and communication issues. The second most common response was that the client was not suitable for IAPT, meaning they are an inappropriate referral (e.g. due to the severity of their health condition). The third most common response was that the client *'declined treatment'*, as they did not want to undertake therapy. In the latter situation, participants should not have been referred into the IPS service, however interestingly, a few people who did not want IAPT *did* want the IPS support. Indeed, as suggested in interviews with participants, there may be some case for allowing people to undertake IPS without the IAPT component (particularly those who have undertaken therapy previously or are already receiving treatment).

Inability to provide parallel service delivery: Pilot sites were severely limited in their ability to provide "parallel" delivery of IPS and IAPT services – a key aspect of the pilot. Unfortunately the waiting lists for IAPT services found in most pilot sites were problematic for providing such support. As discussed above, many people after being triaged waited considerable periods of time before being able to access the IAPT service, and then IPS support. This was especially problematic as many people were seen as wanting to access IAPT before they felt ready to seek employment.

Insufficient time to deliver services or develop good partner relationships: the length of the pilot and the amount of preparation time was considered insufficient and did not allow sufficient time for IPS services to form adequate links with partner organisations (IAPT and JCP) nor to embed the service with employers. This severely limited the ability to support participants to achieve employment, or for health outcomes to be collected and monitored. In addition, many employment specialists were concerned that ending the pilot before they had time to provide support for participants would leave them stranded. A related issue was the speed with which the pilot commenced, not allowing the new services in particular time to recruit staff or to get organised with partners as they would have liked (and as would have benefitted the project). Though co-location of IPS and IAPT services was seen positively, it may not be necessary if there are sufficiently strong partnership connections between services.

Inconsistent fidelity to the IPS model: Related to above, the length of the pilot meant that IPS services were not able to provide support which was fully reflective of the principles of IPS e.g. in terms of providing ongoing in work support and building relationships with local employers. For services that were not established prior to the pilot (or were not a Centre of Excellence), there was no opportunity to ensure fidelity to the IPS model and therefore to assess the quality of the service. Full caseloads are required to conduct fidelity testing. It is noted that the Centre for Mental Health provided full IPS training to all employment specialists participating in the project and monitored site performance through regular

meetings.

Incomplete data on measures: Difficulties were experienced in collecting the Management Information for this project. This was largely due to data being required from two different services, which were not necessarily co-located. There was no additional funding for data management, and its collection was achieved only through the buy-in of individuals with sufficient time from both IPS and IAPT services. Of particular note was whether IAPT participants were aware of the need to complete the additional WHO wellbeing measure. Issues were also identified with data sharing/patient confidentiality and patient identification where services were not co-located. In addition, the short time frame for the pilot and the delay in accessing IAPT, meant that for many of the participants, the final scores for the measures were not collected, as treatment had not been 'completed.'

4.2 Recommendations

In this section we make recommendations to inform the development of a larger scale pilot. The focus of a larger scale pilot should be on maximising employment and employment-related outcomes for service users, as well as increasing referrals and participation.

The following recommendations provide both general advice for how to 'scale-up' a pilot, while also providing advice which relates directly to the issues identified in the above conclusions.

1. Increase time for the pilot

More time for a pilot is required in terms of more time **for set-up**, more time **for the service to embed**, and to allow the provision of some **'wind-down' support** after the pilot has finished. It is recommended that there is:

- ***A period of at least 6-8 weeks allocated as 'set-up' time prior to the pilot service commencement date.*** This is to ensure that the service is ready to provide high quality services from the commencement date. This would allow time:
    - For recruitment, training and embedding employment specialists in services and localities/communities (including developing links with local employers).
    - For planning and implementation of a recruitment strategy, likely to include staged recruitment as more referrals come into the service, to improve cost-effectiveness given the slow start to referrals experienced in this pilot (e.g. including consideration of local IAPT waiting times, and JCP ESA Work Coach advice on likely numbers of referrals).
    - To market the IPS service to potential service users, in particular through proactively engaging IAPT and JCP partners, to secure their buy-in early – seen as key to the success of the pilot. Early engagement of IAPT is also crucial to ensure required data is collected.
    - To allow appropriate referral criteria and referral routes to be developed with

the input of all three partner agencies, and ensure these are communicated to and understood across the JCP, IAPT and IPS service providers.

- ***A period of at least 12 months for service operation.*** This is to increase access to more clients, to allow a better quality of IPS and IAPT service provision, and to optimise employment outcomes. This would allow time:
    - For the IAPT and IPS services to be delivered in parallel, even where there are long waiting lists for IAPT in many areas.
    - For more individuals to complete IAPT treatment during the course of the pilot.
    - To resolve any partnership and referral issues early enough for this to have an impact on service delivery during the pilot.
    - To allow early assessment of IPS fidelity and opportunities for service improvement within the course of the pilot.
    - For IPS services to achieve fidelity by having the time to provide ongoing in-work support to participants and employers.

- ***Consultation with service providers to identify appropriate ways to 'end' the project, to prevent people being abruptly left without IPS or commensurate support when the pilot ends.*** This will:
    - Increase the chance that service users will 'complete' IAPT provision.
    - Link service users into alternative services to ensure they have ongoing employment support, for those who have and have not found employment.

2. Enhance the partnership relationship between IPS and IAPT providers

Though the model proposed for the pilot was described as IAPT *plus* IPS support, in practice, it was felt that the IAPT services were less engaged. It was suggested that not all IAPT providers understood the purpose of the pilot, their role in it, or the purpose of IPS. This was likely exacerbated by the current high pressure on many IAPT providers, limiting their ability to engage with additional activities. It was further suggested that given IAPT requires GP or self-referral, it was difficult to distinguish between self- referrals made by pilot participants and those made by others. It is recommended that:

- ***Early consultation is undertaken with both IPS and IAPT to inform the development of a larger scale pilot and secure buy-in.***
- ***Particularly where services are not co-located or co-managed, regular 'partnership' sessions/meetings be encouraged, to facilitate both parties discussing the pilot, what is and isn't working, and develop solutions together. This should include IAPT local team, not only IAPT managers.***
- ***Both IPS and IAPT services are engaged in the development of clear, locally***

specific guidance on eligibility criteria and referral pathways.

- ***IPS and IAPT services are encouraged to learn more about each other. Short training sessions should be undertaken by all IAPT providers participating in the pilot to ensure some understanding about IPS.***

3. Enhance parallel provision of IPS and IAPT services

A major barrier to the provision of support in this pilot was the inability in many cases to provide IPS and IAPT at the same time – particularly in the first few months of the pilot given the waiting lists for IAPT. This delay before commencing services might be less problematic in a longer pilot, as there will still be time to complete at the end despite a slow start. Furthermore, from April 2015 IAPT services will be required to treat 75% of people referred within 6 weeks and 90% within 18 weeks. However, the issue of the IAPT service's ability to deliver quick access still presents a barrier to engaging people with IPS support, and therefore to making best use of the IPS provision. Recommendations are:

- ***Explore the possibility of providing IAPT services participating in a second phase pilot with funding to resource extra therapeutic support which could be used to meet additional demand. Funding packages could be negotiated with local IAPT services, conditional on meeting (or showing progress towards) meeting IPS in IAPT waiting times, to be decided as appropriate to local conditions.***

- ***Explore the potential benefits and impact of people beginning IPS six weeks after referral to align with new IAPT waiting time standards so to enable parallel provision.***

4. Enhance partnership working with Jobcentre Plus

Though Jobcentre Plus (JCP) were the gateway through which clients would enter the pilot, the JCP ESA Work Coaches felt they had not been given necessary information about the pilot and its operation in a clear nor timely fashion. This prevented them from contributing as well as they might, and presented a barrier to referral numbers. It is recommended that:

- ***Early engagement takes place with JCPs to raise awareness of the pilot and operation. This should include a short training session to be undertaken by all JCP ESA Work Coaches to communicate what IAPT and IPS are and what they can offer clients.***
- ***Work be undertaken to enhance JCP ESA Work Coach working relationships with IPS and IAPT partners, e.g. Regular meetings, part-time colocation of IPS provider in JCP.***
- ***JCP be engaged at an early stage in the development of referral criteria and pathways.***

- ***Clear, locally specific guidance be developed on eligibility criteria and referral pathways, with agreement from all three organisations.***
- ***Feedback loops be developed to ensure JCP ESA Work Coaches are aware of what has happened to their clients.***

5. Permit the option for IPS without IAPT

In many cases, service users wanted to commence IAPT before entering the IPS service. As recommended above, action needs to be taken to ensure that this can occur within an acceptable waiting time. However, in some cases it was identified that service users would have been (and were) happy to access the IPS element while waiting for the IAPT, or that they did not want IAPT at all (particularly where they had had it previously, or were already receiving treatment). For those who wish to find work but do not wish to undertake IAPT services, the mandatory nature of the therapeutic element for entry into the pilot is a barrier to accessing employment support. It is recommended that:

- ***An 'IPS only' option be made available for these specific cases, e.g. where individuals are already undergoing treatment, have previously been engaged with IAPT, or there is a prohibitively long waiting list for IAPT. It is suggested however that employment specialists try to guide service users towards accessing treatment for their mental health condition, but respect this as an option.*** (it is noted that this may cause issues with administration – these are discussed in recommendation 9)

6. Local project/service manager to be assigned to each site (from IPS or IAPT as locally appropriate)

Management of the IPS and IAPT provision varied from site to site – in some cases operating separately, and with different services taking the lead. It was not clear which model worked better at the pilot stage – though those with separate IPS and IAPT appearing to perform better, it must also be noted that these were previously established, high quality services. What was clear from the pilot was that there needed to be improved opportunity for the two service elements to work in partnership, irrespective of team location. For those given the task of managing the pilot, at all sites the individual who took this role reported it severely impacted their ability to manage their usual workload. It is recommended that:

- ***Consideration be given to providing additional funding for a 'project manager'. The project manager, whether 'located' in IPS or IAPT, would be co-funded. They would have a designated list of responsibilities for management of the pilot. Key to this would be the enhancement of the coordination of the IPS and IAPT provision, stakeholder communication, identification of opportunities for enhancement of relationships, and ensuring effective data sharing and service user tracking (especially in regards to service user identifiers)***
- ***There would be value in providing a named contact to manage the relationship***

with the JCP.

7. Consider broadening of eligibility criteria

The eligibility criteria for referral into the pilot were highlighted as an issue early on by service providers and JCP ESA Work Coaches. Though the criteria were widened during the pilot, service providers, and particularly the JCP felt that there was considerable merit in extending the pilot to allow wider access. It is recommended that:

- ***Consideration be given to extending the pilot to other clients. As suggested by Work Coaches, this might include those in the ESA Support Group with a longer prognosis and to those on JSA. It was further suggested that this might be seen as alternative to the Work Programme for all clients with mental health conditions.***

8. Improve communication with clients/service users

Service users, though generally highly positive about the service, felt misled about the opportunity for timely access to IAPT, and did not feel that they had been provided with sufficient information about the pilot and processes involved. It is recommended that:

- ***User-friendly, plain English information on the pilot be developed and provided to potential service users, to ensure they are clear about what the service offers, what it involves, and the estimated time frames. This should include a 'pathway' to ensure service users are clear who will contact them and when, and to what end.***

9. Improve data collection and data management

The collection of data across two different services was problematic, particularly where services were not co-located, but in general due to difficulties in sharing NHS patient data with a non-NHS service (IPS). Similarly, IAPT services have their own patient identifier numbers, which may not always be possible to share with IPS (though this did happen at some sites), making patient identification across both services difficult – perhaps even more so when a patient was referred to IPS first, as the IAPT service would not be aware that an individual self-referring to IAPT was in the pilot.

Leadership was needed to ensure that IAPT were fully in engaged in data collection, in particular the use of the WHO wellbeing measures.

More generally, data collection around service use and the measures from two services was time consuming even for low numbers of service users. In a larger scale pilot this will likely be increasingly difficult.

Consideration needs to be given to how to provide better data management to pilot

participants for a larger scale pilot. This needs to include consideration of issues such as:

- ***Budgeted provision for data management support at each pilot site. Whether this be to the end of creating a shared client management system, or time for a nominated administrator at each site, with strong links to both IPS and IAPT services.***
- ***How to facilitate secure transfer of data between IAPT and IPS services.***
- ***Whether shared data protocols can be devised.***
- ***Whether shared unique identifier numbers can be used for pilot participants across IPS and IAPT services.***
- ***How to provide notification to IAPT (from IPS) that an individual is in a pilot (e.g. incorporating on patient record).***

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Appendix A Descriptions of sites

Site A: An established IPS service provider led the pilot. They are a pre-existing Centre of Excellence. They worked with 3 local IAPT services to deliver the pilot. Site A took on an additional 5 IPS workers and receive referrals from 13 jobcentres.

Site B: The IAPT service at site B offers IAPT as part of a wider programme for people with mental health problems. They have an integrated IPS service which they already offer to clients receiving IAPT and are the only site of the four pilot areas to have a pre-existing co-located IPS and IAPT service. They cover the smallest geographical area on the pilot and receive referrals from two jobcentres (with another jobcentre providing partial referrals). The have recruited four more IPS workers for the purposes of the pilot.

Site C: The pilot was led by the local IAPT service. Site C covered the largest geographical area of the four pilot sites. This was the only site out of the four that did not have an existing Individual Placement and Support service in the locality (though employment support was previously provided through the IAPT, primarily focused on job retention). Four IPS workers have been recruited, two of whom already worked with IAPT as above. They receive referrals from eleven local jobcentres.

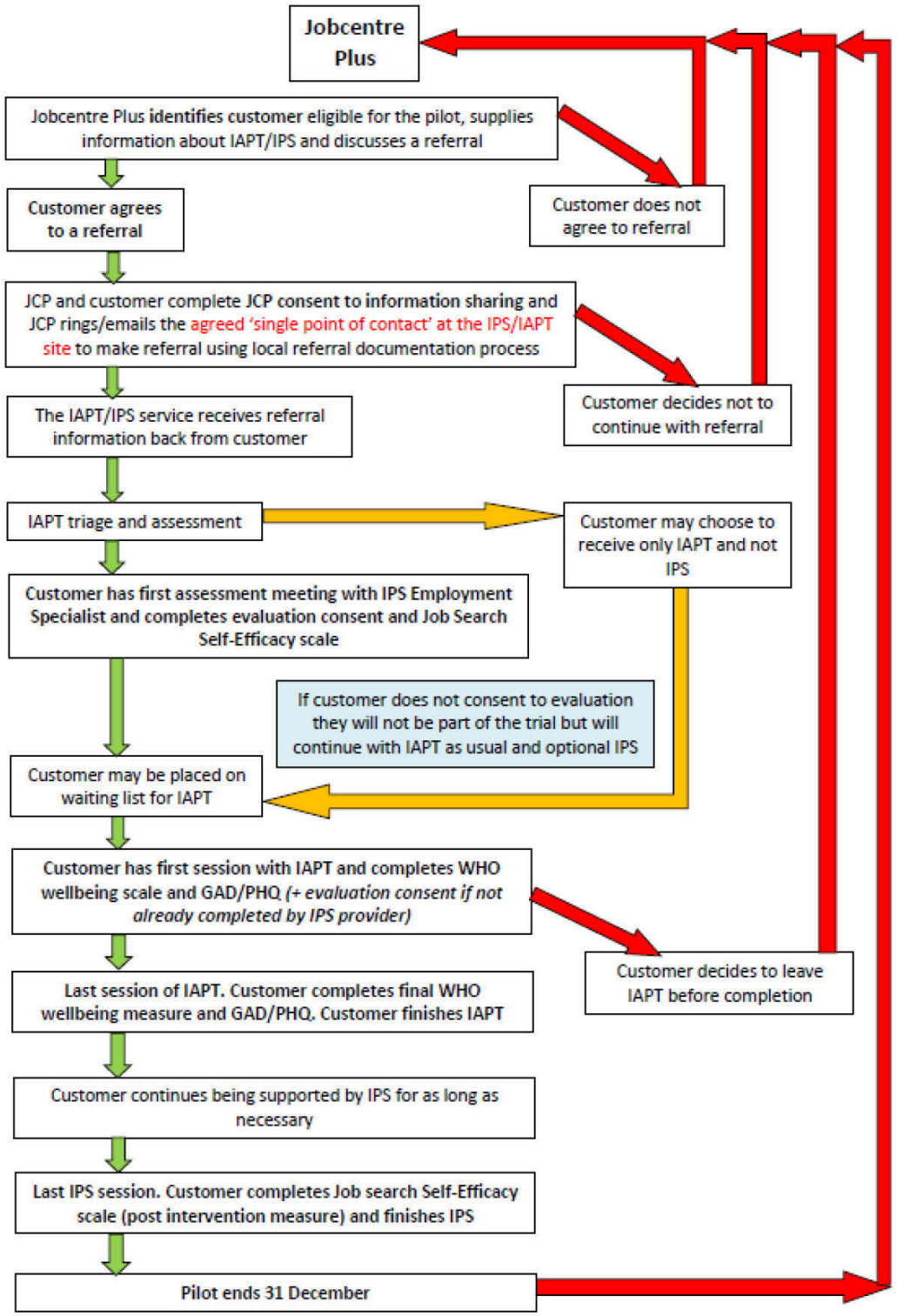
Site D: The pilot was led by an existing IPS service. They are a pre-existing Centre of Excellence. IAPT was delivered by local NHS Foundation Trusts. They recruited six new IPS workers for the purpose of the pilot. They receive referrals from seven local jobcentres.

Appendix B Job Search Self-Efficacy (JSSE)

Whether or not you are employed or unemployed now, how **confident** do you feel about doing the following things successfully?

Circle one number per item	Not at All				A Great Deal
1. Making a good list of all the skills that you have and can be used to find a job	1	2	3	4	5
2. Talking to friends and other contacts to find out about potential employers who need your skills	1	2	3	4	5
3. Talking to friends and other contacts to discover promising job openings that are suitable for you	1	2	3	4	5
4. Completing a good job application and resume	1	2	3	4	5
5. Contacting and persuading potential employers to consider you for a job	1	2	3	4	5
6. Making the best impression and getting your points across in a job interview	1	2	3	4	5
7. Searching for jobs online (using computers, smart phones, internet, etc.)	1	2	3	4	5
8. Applying for jobs online (using computers, smart phones, internet, etc.)	1	2	3	4	5
9. Getting help in order to become familiar with a new job	1	2	3	4	5

Appendix C Flow Chart



Outline description

The flow chart begins: Jobcentre Plus identifies customer eligible for the pilot, supplies information about IAPT/IPS and discusses referral.

1. Customer does not agree to the referral – *they return to the regular Jobcentre Plus service*.

2. Customer agrees to the referral, they and JCP complete the consent to information sharing and JCP contacts the local IAPT/IPS site using the agreed process.

    a) Customer decides not to continue at this point – *they return to the regular Jobcentre Plus service*.

    2.1. The Customer completes IAPT/IPS forms and returns them to the service.

    2.2. IAPT service triages and assesses the Customer.

        a) Customer opts to receive only IAPT and not IPS, *they proceed to 2.4 but do not participate in IPS activities*.

    2.3. Customer has assessment meeting with IPS Employment Specialist, completes evaluation consent and Job Search Self-Efficacy scale.

        a) Customer does not consent to participate in the evaluation – *they continue with IAPT as usual with optional IPS but is not part of the trial.*

    2.4. The Customer may be placed on the waiting list for IAPT.

    2.5. Customer attends first IAPT session, completes WHO wellbeing scale and GAD/PHQ and evaluation consent if not already completed by IPS service.

        a) Customer does not complete IAPT – *they return to the regular Jobcentre Plus service*.
        b) Customer does not consent to participate in the evaluation – *they continue with IAPT as usual with optional IPS but is not part of the trial.*

    2.6. Customer attends final IAPT session, completes final WHO wellbeing scale and GAD/PHQ.

    2.7. Customer receives support from IPS service for as long as necessary.

    2.8. Customer attends last IPS session, completes final Job Search Self-Efficacy scale.

    2.9. Pilot ends 31 December 2014 – *all participants return to regular Jobcentre Plus service*.

Acknowledgements

The authors would like to thank Centre for Mental Health for their ongoing support and advice during the evaluation particularly Jan Hutchinson, as well as the service and data managers at each pilot site who responded to multiple queries through the course of the pilot. We would also like to thank colleagues at The Work Foundation – Victoria Shreeve and Dr Tyna Taskila for their help conducting and analysing service user interviews, and David Shoesmith who helped to edit the report. We would also like to thank everyone who participated in the pilot, especially the staff and service users who contributed to the interviews and focus groups.

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