Individual Placement and Support: It’s everyone’s business

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Many people want to work but...

• In comparison with people with other health conditions, people with mental health conditions are twice as likely to lose their jobs following the onset of problems (Burchardt, 2003)

• 7.9% of people on CPA are in employment (NHS Information Centre, 2011)

• 57% people using mental health services were offered help with finding or keeping work however 43% were not but would have liked help
  – 35% on CPA
  – 49% not on CPA (CQC, 2011)
Is this our job?

"We have to aim higher, particularly when it comes to Recovery. There has been progress in recent years. Some organisations are doing fantastic work to help people reclaim their lives and meet their personal ambitions”

Paul Burstow MP
Minister of State for Care Services
2011
‘I was told I had something I had never heard of before, schizophrenia. I cannot remember much about my admission apart from hearing voices and feeling very sedated. I had been working as a cleaner at a bus company, the money I earned enabled me to support my family abroad. Being in hospital meant that I could not work and I was terrified of losing my job. As I got better, I worked with the employment specialist to agree with my employer a return to work schedule. I started with working 2 hours a day and eventually, was able to return to my full time working hours of 42 hours a week.’
'My Psychiatrist suggested that I might find it useful to speak to an employment specialist. I don’t think that I had any idea of what to expect but simply being asked the question made me feel like I might still have a working future.’

‘I decided to get back to work quickly, as for me this gave me something to get out of bed for and focus my energy on instead of staying under the duvet. It was just a normal job in a shop for 4 days a week, but I made sure I was committed and on time. I have now been in my job 6 months without 1 day off sick.’
Challenges

• National / regional / local systems
  – Health, Social Care, Welfare systems
  – Welfare benefits

• Myths and assumptions
  – People with severe mental health conditions cannot work...
  – If they do it will be stressful and lead to a relapse...
  – Our job is to protect the public and the individual....

• Local technical issues
  – Adopting IPS
  – Early implementation
  – Persistence / sustainability of implementation
IPS: Integrated systems

• Health, social care and employment support should be integrated and provided in parallel

• No grounds for selecting people on the basis of their ‘work readiness’ or ‘employability’

• Focus should be on employment through job matching based on client skills and preferences, rapid job search and support for as long as necessary

• Welfare systems need to support the transition to employment
Integrating employment & clinical services
What are the benefits?

- Clinically sensitive intervention
- Addresses concerns that employment serves as a stressor
- More effective engagement, retention and communication
- Incorporation of vocational information into care plans
- Observation can convert sceptical or disinterested clinicians
- Job retention
- Better outcomes – more people get and keep jobs

Drake et al, 2003
Employment is a realistic goal

Job Ready?

- Diagnosis and symptoms do not predict success
- Having previously had a job is important but wanting a job and believing that you can work are the best predictors of success (Tsang et al, 2000; McDonald-Wilson et al, 2001; Catty et al, 2008)
- Shared decision-making?

Is work too stressful?

- As compared to what?
- If you think work is stressful, try unemployment (Marrone & Golowka, 1999)
Clinicians’ attitudes...

- Clinicians believed that many more people were capable of working than were actually doing so.
- However, 2/3 believed their caseloads either incapable of working or only able to do voluntary /sheltered work.
- Clinicians saw helping people get back to work as a core part of their role, but felt they had little relevant training and limited confidence in the vocational services currently available.

Marwaha et al, 2008
Can people with longer term mental health conditions work?

The research evidence:

• Individual characteristics have little impact on employment outcomes … no justification for excluding people on the basis of clinical history, ‘employability’, ‘work readiness’…

• Sheltered workshops and pre-vocational skills training not very good at helping people to return to work

• There is strong evidence that with the right kind of help people with serious mental health problems can successfully gain and keep work

See, Crowther et al, 2001; 2010
Individual Placement & Support (IPS)

• Not a new intervention

• A robust evidence based intervention

• Research findings consistently more superior than other approaches to vocational rehabilitation (2-3 times more effective)

• Generalisability: USA, Canada; Europe (8 countries); Hong Kong; Australia; New Zealand

• Emerging evidence base for young people with a first episode of a psychosis

• Fidelity scale
Individual Placement & Support (IPS)

- ‘Place and train’ approach **not** ‘train and place’...
  - Focus on competitive employment as a primary goal
  - Eligibility based on the individual’s choice
  - Rapid job search, minimal pre-vocational training
  - Integrated into the work of the clinical team
  - Attention to client preferences
  - Availability of time unlimited support
  - Individualised welfare benefits counselling

(Bond, 2004)
IPS trials

Supported employment  Control
First Episode Psychosis: Employment

Research to practice....

WHAT HAVE YOU LEARNT FROM THE COCHRANE COLLABORATION?

LIFE IS FULL OF TRIALS
Routine clinical practice

Young people with a first episode of psychosis

Community impact: One London borough

Percentages of Merton long-term clients engaged in work or employment

- Open employment
- Mainstream education
- Voluntary Work
- Sheltered work

Role of Employment Specialist

• Co-ordinates vocational plans with clinical team

• Individualised approach with clients
  – Client preferences influence the vocational pathway

• All phases:
  – Engagement, assessment, job development, support re welfare benefits and addresses the support needs during the transition to and once in employment

• Active job development, working with employers – individualised approach
Implementation: More than Employment Specialists

- Changing the behaviour of Health & Social Care staff and other key staff
- Changing the organisational structures, cultures, and climates
- Changing systems and policies, as well as relationships with external partners
- Minimising the research to practice gap
Fidelity

- Effects of intervention depend on how it is delivered
- Programmes that faithfully implement the key elements of an IPS have better outcomes
- IPS fidelity scale has predictive validity - positive associations with employment outcomes (see Becker et al. 01, 06; McGrew et al. 05; Burns et al. 07; Bond et al in press).
- IPS fidelity scale: the *what* and *how*
- A tool in research **but more importantly** a day to day management tool
Lessons learnt

- Understanding local need
- Discussing the myths…. Relapse / hospitalisation
- Integrating an employment specialist
  - Equal member of the team
  - Clinical and managerial leadership
  - Job retention and supported education
- Be prepared and do your research

Resistance and problems

• **Work with all team members:**
  – Rapid job search - does not necessarily mean clients move rapidly into jobs
  – Clear monitoring to see outcomes from teams, role of stories

• **Clients and carers:**
  – clients with the most complex health and social care needs

• **Partnership working:**
  – Strengths based, capacity building

• **Employers:**
  – Employers do not recruit ‘schizophrenia’ any more than they do ‘heart disease’ … individualised approach

Challenges: Myths

• People can work if provided with right help and support
  – ‘Place and train’ not ‘train and place’

• IPS helps more people to find jobs and raises their incomes along with higher rates of improvements in symptoms, leisure and finances, self esteem and relationships (Cook & Razzano, 2000; Bond, 2001; Leff & Warner, 2006; Becker et al., 2007, Burns and Catty, 2008).

• No evidence that IPS increases the likelihood of clinical deterioration, relapse or hospitalisation (Bond et al., 1995; Lehman, 1995; Drake et al., 1996; Drake et al., 1999; Bond et al, 2001; Mueser et al., 2004; Burns et al., 2007)
Implementation Obstacles

- Lack of early intervention
- Failure to adopt evidence based practice
- Lack of focus on work resumption
- Lack of integrated service / fragmented provision
- Lack of case management
- Low priority for clinicians
- Interagency co-operation poor
Thank you

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