Article:
Whitworth, A. orcid.org/0000-0001-6119-9373 (2018) Mainstreaming effective employment support for individuals with health conditions: An analytical framework for the effective design of modified Individual Placement and Support (IPS) models. Social Policy and Society. ISSN 1474-7464

https://doi.org/10.1017/S147474641800043X

This is an open access version of the article published in Social Policy and Society (2018) https://doi.org/10.1017/S147474641800043X. To cite the article please use: Whitworth, A (2018) 'Mainstreaming effective employment support for individuals with health conditions: an analytical framework for the effective design of modified Individual and Placement Support (IPS) models', Social Policy and Society. https://doi.org/10.1017/S147474641800043X

Mainstreaming effective employment support for individuals with health conditions: an analytical framework for the effective design of modified Individual Placement and Support (IPS) models

Abstract

Individual Placement and Support (IPS) is a highly effective model of employment support for individuals with severe mental health conditions. Its potential modification for new settings and larger cohorts is of keen interest across advanced economies given shared health-related (un)employment challenges. Despite mushrooming policy interest and activity around modified IPS a significant barrier and risk presently is the absence of a well-considered analytical framework to enable structured critical reflection about the effective translation of IPS principles and fidelity into modified IPS services. This article fills this void through the presentation for the first time in the literature of such an analytical framework, unpacking as it does so a set of key original analytical distinctions that are unhelpfully homogenised in current literature and policy thinking and highlighting the wider potential of IPS principles and models to the nature of good employment support for other individuals with health conditions and disabilities.

Keywords: Individual Placement and Support; IPS; fidelity scale; disability employment gap; work and health.

This is an open access version of the article published in Social Policy and Society (2018) https://doi.org/10.1017/S147474641800043X. To cite the article please use: Whitworth, A (2018) 'Mainstreaming effective employment support for individuals with health conditions: an analytical framework for the effective design of modified Individual and Placement Support (IPS) models', Social Policy and Society. https://doi.org/10.1017/S147474641800043X

Introduction

The linkages between ill health and weaker employment opportunities and experiences are strong, bi-directional and well-evidenced, whether thinking about unemployment, precarious employment, sickness absence (absenteeism) or reduced productivity (absenteeism) (Eurostat, 2018). Good work is known to be beneficial to mental and physical health (Waddell & Burton, 2006; Dolan et al., 2008; Oguz et al., 2013) and the scale of health-related unemployment, absenteeism and presenteeism across advanced economies harms individuals, communities, employers and Exchequers alike (OECD, 2015).

It is difficult to overstate the scale of the challenge and of the support need – the percentage point difference in the employment rate of working age adults with a disability or health condition compared to those without – is negative, sizeable and stubborn across countries (DWP-DH, 2016; WPSC, 2017; Eurostat, 2018). Of concern is not simply the scale and depth of these negative impacts but also the near complete lack of positive change following at least two decades of repeated employment support interventions across advanced economies aiming to shift this disappointing position (van Stolk et al., 2014).

This is not to say that employment support programmes can resolve this issue alone. Changes in both the casualization and intensification of the labour market continue on the one hand to create a reality where many jobs cannot be considered to be 'good'. On the other hand the near wholesale policy adoption and then – to varying degrees – simplification of the evidence has led in some national contexts to the hardening of welfare systems that unhelpfully threaten and coerce unemployed individuals with health conditions and disabilities into any paid employment irrespective either of its nature or the individual's need and desires, both key factors to whether paid work is in fact beneficial to wellbeing.

Whilst recognising that the wider economic and social context within which social policy interventions such as these sit remain key, there remains nonetheless a significant need to rethink the nature of employment support for individuals with health conditions such that they deliver a step-change in support experiences and sustained employment outcomes that contribute to positive wellbeing gains and improvements in quality of life. Whilst many interventions have demonstrably failed over recent decades, a significant body of solid evidence has developed across multiple robust evaluations around a model of employment support known as Individual Placement and Support (IPS) for individuals with severe mental health conditions within secondary mental health services (Bond et al., 2008; Burns and Catty, 2008; Marshall et al., 2014; van Stolk et al., 2014; Mueser et al., 2016; Modini et al., 2016; Suijkerbuijk et al., 2017). The IPS model emphasises client preferences and operates a rapid place-then-train employment model in which competitive employment of well matched jobs is the goal, with individuals supported intensively by employment specialists with low caseloads and who are integrated into mental health teams.

The effectiveness and cost-benefit of the IPS model is substantial and undeniable, even if leant towards a US evidence base (Bond et al., 2012a). A major recent RAND evidence synthesis concludes that IPS is the leading policy option that governments should consider to support individuals with health issues into paid employment (van Stolk et al., 2014). Summarising the evidence base across 17 randomised control trials, Marshall et al. (2014) conclude that IPS services show a 58 to 60 per cent employment rate compared to a 23 to 24 per cent employment

This is an open access version of the article published in Social Policy and Society (2018) https://doi.org/10.1017/S147474641800043X. To cite the article please use: Whitworth, A (2018) 'Mainstreaming effective employment support for individuals with health conditions: an analytical framework for the effective design of modified Individual and Placement Support (IPS) models', Social Policy and Society. https://doi.org/10.1017/S147474641800043X

rate for randomly assigned control groups – staggeringly high effects compared to those seen in evaluations of mainstream employment programmes.

Despite its significant potential, however, traditional IPS is a niche employment support model that is in its current configuration ill-suited to making significant inroads into the totality of the health-related (un)employment challenge across advanced economies, even if some experimentation with IPS to new cohorts, settings, functions and larger volumes has occurred (Li Tsang et al., 2008; Coole et al., 2012; Ferguson et al., 2012; Luciano et al., 2014; Sveinsdottir et al., 2014; Ellison et al., 2015; Poremski et al., 2017; Smith et al., 2017). Specifically, traditional IPS is limited in four key respects:

- Cohort: IPS models have supported individuals with severe mental health conditions only, despite the far larger number of individuals with low to moderate mental health issues in need of support and the frequent co-occurrence of mental and physical health issues (comorbidity);
- Setting: IPS models have operated in secondary mental health services, but only a small minority of the wider cohorts identified above are (rightly) ever supported in such services;
- Function: IPS services have focused exclusively on the out-of-work cohort, despite the significant support needs for those already in employment around absenteeism (e.g. sickness absence) and presenteeism (e.g. reduced productivity);
- Scale: IPS services have operated at low volumes, in contrast to the far larger size of the challenge presented by mainstream low to moderate health cohorts in need of similarly effective employment support.

Alongside the interest in what we will term traditional IPS, there is therefore an understandable significant parallel policy interest and activity around flexing the IPS model into what we term modified IPS services in the face of this combination of impressive IPS evidence, the pressing need to do much more, and the inability of the IPS model in its current form to bridge the gap. Whilst needed and welcome, therefore, the flurry of newly emerging funding and activity around modified IPS services is at present also a source of risk to the experiences, outcomes and value-for-money of this due to the absence of a well-considered analytical framework within which commissioners and programme designed are enabled to reflect critically about the nature, and resulting expected effectiveness, of the modified IPS programmes that they are creating. The original development of that critical analytical framework is the chief task of the discussion that follows, informed by the author's embedded policy experience codesigning one such modified IPS service.

Critically reflective codesign of a large-scale modified IPS service

Since autumn 2016 the author has been seconded into regional policy partners leading an intensive programme of codesign work of a large-scale modified IPS trial within a UK Combined Authority – a tier of devolutionary government comprising multiple local authorities across a city-region geography.

Sponsored by the UK central government joint Work and Health Unit (WHU), the shared opportunity and challenge has been to design, commission and mobilise an innovative modified IPS trial to support around 3,750 residents with low to moderate mental health and/or physical

health conditions in primary and community care settings and incorporating both those who are out-of-work and seeking employment as well as those who are in-work but off-sick or struggling at work due to their health condition. Voluntary in nature, the modified IPS trial will run between 2018 and 2021 within a randomized control trial (RCT) framework. It is to our knowledge the world's largest IPS trial and will produce a wealth of evidence of unprecedented depth and richness about what works best for whom and why (or, equally valuable, why not).

The codesign thinking took place weekly for a roughly twelve month period from Autumn 2016 to collectively develop the detailed design of our modified IPS service such that it satisfied three key criteria: firstly, that it incorporated evaluation learnings from the IPS literature around the links between fidelity, key characteristics, and performance; secondly, that it worked appropriately for the trial's differing target cohort, taking into account during the codesign process the views of service users, health practitioners and employers in a series of local stakeholder workshops; and thirdly, that it map effectively onto the local health systems of the five local areas involved in the trial such that it would both work effectively in live-running and be able to be sustained afterwards. Alongside the author as codesign lead, the codesign group comprised a local lead from each of the five areas involved and central government colleagues from the joint Work and Health Unit. These local leads were key to discussion and also acted as a conduit to further consultation to wider stakeholders in their local areas between codesign meetings. Local leads all worked around the work-health agenda within their organisations with a constructive mix of roles and organisations – some senior public health leads, some senior health commissioners, others employment leads.

Central to the effectiveness of IPS is the twenty-five item fidelity scale shown down the left column of Table 1 against which IPS services can be measured in terms of their fidelity and quality (CMH, 2015). For traditional IPS services the fidelity scale is a powerful guide to designing and delivering high quality IPS services and performance. Given the activity, trialling and effectiveness of IPS services over the past twenty years, and given the central place of IPS fidelity to the IPS model, the IPS fidelity scale has understandably been the subject of significant attention within the academic literature in a range of ways including: the creation and evolution of the IPS-25 fidelity scale (Bond et al., 1997; Bond et al., 2002; McGrew and Griss, 2005; Bond et al., 2012b); the link between employment outcomes with the total fidelity score (Lockett et al., 2011; Bond et al., 2012b; Kim et al., 2015) and, as important but less commonly, individual fidelity items (Bond et al., 2012b; Kim et al., 2015; Margolies et al., 2018); sub-dimensions of the fidelity scale (Bond et al., 2002); differing levels or types of fidelity scale (Mowbray et al., 2003; Bond et al., 2011); fidelity assessment and self-assessment (Bond et al., 2011; Margolies et al., 2017); and the moderating role of individual and contextual factors between IPS fidelity and employment outcomes (Campbell et al., 2010; Metcalfe et al., 2018).

Of particular relevance to the present argument, modification of IPS fidelity and services has also been a lively area of activity and discussion in the literature (Paulson et al., 2002; Mowbray et al., 2003; Bond et al., 2011; Luciano et al., 2014), whether that augmentation be to add additional programme elements felt to be potentially useful – for example a growing evidence base around the benefits of including additional cognitive remediation elements (McGurk et al., 2007) – or else to remove or dilute programme elements in order, for example, to reduce costs – for example evidence that IPS time-limited to nine months rather than being time-

unlimited, as per traditional IPS fidelity, may be virtually as effective but markedly more cost efficient (Burns et al., 2015). Whilst many wish to modify IPS to seek to harness the effectiveness of traditional IPS in new contexts, cohorts and settings, given that the traditional IPS fidelity scale is well validated, linked to more positive outcomes and a powerful tool to drive model adherence during implementation an alternative strand of the literature rightly argues that augmentation away from the evidence-based practice of the IPS fidelity scale must proceed with caution (Bond et al., 2011). Where cohorts, contexts, functions and volumes vary from traditional IPS services as in this policy case study, however, modification may be necessary and appropriate. The key challenge then is to effectively flex the fidelity items as required for the differing needs of their larger and wider cohorts and primary care contexts whilst retaining the core ethos, quality and performance of the IPS. If, why and how to augment IPS fidelity then, and with what implications for this particular policy case study?

The right hand column of Table 1 shows the fidelity scale of our codesigned modified IPS service based on its differing cohorts and needs and our wider local system. No fidelity items are added or removed and whilst most remain identical to the traditional IPS fidelity scale several are adapted for our intervention. Reflecting on the evolution of the IPS fidelity scale itself, Mowbray et al. (2003) outline distinct empirical, practical and theoretical approaches to fidelity modification. Our approach to the modification of the IPS fidelity scale through the codesign process combines practical and theoretical approaches – a practical flexibility to bend certain items within limits to fit with the differing needs of our intervention (cohorts, functions, local health and employment system, etc) compared to a traditional IPS service whilst retaining a theoretical commitment to ensuring that the programme theory and 'cognitive blueprint' of IPS are retained. Given that this programme is a randomised control trial where programme fidelity, programme effectiveness, and the links between the two (at both total scale and item-level) will be evaluated, it will in time also be possible to conduct empirical assessment of these modifications.

Table 1 highlights that there is significant overlap between the two fidelity scales despite the differing cohorts – and resultant service needs – of a traditional IPS service and this codesigned modified IPS service. We term these 'standard IPS fidelity items' and these are shown in Table 1 as items that are – and ought appropriately to be – shared items of equal relevance across both traditional fidelity and modified fidelity scales and according to the same underlying measurement and scoring criteria. The challenge for modified IPS services is simply to deliver these items as fully as possible within their services according to exactly the same quantitative scale and scoring system as in any traditional IPS service.

For modified IPS services the key challenge is to effectively flex the fidelity items as required for the differing needs of their larger and wider cohorts and primary care contexts whilst retaining the core ethos, quality and performance of the IPS. The right column of Table 1 highlights in italicised text those fidelity items that our codesign work identified as in need of modification on order to function effectively for our modified IPS trial, as guided by the practical and theoretical approaches to modification outlined by Mowbray et al. (2003). These fidelity items are of a qualitatively different nature to the shared standard fidelity items in that whilst they seek to achieve the same intent and ends as those items in the traditional IPS fidelity scale the optimal means of delivering these may in modified IPS services require a reconfiguration of

the item and its underlying scoring criteria given their new cohorts, needs and local systems and contexts. These items are for the first time in the literature identified as qualitatively distinct 'modifiable IPS fidelity items' and it is these modifiable fidelity items that are – and ought appropriately to be – open to careful configuration to deliver their desired intent and ends is dependent upon the needs, opportunities and risks of each specific programme and of the local system context that it sits within. Only then is it viable to consider how best to measure and score these modifiable fidelity items.

This is an open access version of the article published in Social Policy and Society (2018) https://doi.org/10.1017/S147474641800043X. To cite the article please use: Whitworth, A (2018) 'Mainstreaming effective employment support for individuals with health conditions: an analytical framework for the effective design of modified Individual and Placement Support (IPS) models', Social Policy and Society. https://doi.org/10.1017/S147474641800043X

Table 1: Traditional IPS fidelity scale and our trial's modified IPS fidelity scale

Fidelity Scale item	Traditional IPS fidelity scale items	Trial's modified IPS fidelity scale items
1. Caseload size	• Target 20 or less	• Target 30 or less, max 35
2. Employment services staff	• Employment Specialists (ES) provides core employment support and action planning	
3. Vocational generalists	• ES carries out all employment functions • ES may address wider support needs	• ES carries out all employment functions • ES ensures wider support needs are addressed
4. ES integration to health team	• ES integrated into secondary mental health team • Most referrals from secondary mental health team	• ES integrated to relevant primary care team • Referrals from that health team, and beyond
5. ES integration to health practice	• ES participate in host primary care meetings • Co-produced integrated work-health vocational assessment and action planning	
6. Public Employment Service collaboration	• Liaison to enable benefits and return to work advice from public employment service (PES)	• ES provides evidence to satisfy conditionality and ensure effective exit handovers to PES
7. Vocational unit	• At least 2 full time ES and team leader in service unit with weekly meetings	
8. ES Team Leader role	• Team leaders with max 1:10 ratio with ESs • Focus on integration, effectiveness, fidelity, case unblocking, ES support/development	
9. Zero exclusion criteria	• Initial eligibility is individuals in secondary mental health services; out-of-work cohort; voluntary participation • No further exclusion criteria	• Initial eligibility is low to moderate mental health and/or physical health conditions in primary care; 18+; local GP registration; voluntary participation; out-of-work & in-work off-sick/struggling cohort • No further exclusion criteria
10. Trust focus on open employment	• NHS Trust promotes open employment for cohort in strategies, priorities and metrics	• Key organisations promote open employment for cohort in strategies, priorities and metrics
11. Executive support for IPS	• NHS Trust executive Team support IPS in its strategies, priorities and metrics	• Leaders of key organisations have partnership support for IPS in strategies, priorities & metrics
12. Financial planning	• All clients given specialist benefits, tax credits, 'better-off calculations' advice	
13. Disclosure	• Clients given advice to inform disclosure decisions	
14. On-going assessment	• Vocational profiling is live document reviewed through customer journey	
15. Rapid open job search	• Open employment is the day one goal and first job search activity within first 30 days	
16. Individualised job search	• ES delivers job matching personalised to client, based on full holistic assessment	
17. Employer contact frequency	• ES engages employers to source opportunities • Opportunities shared amongst ES team	• ES engages employers and local authority (LA) employer engagement teams • Opportunities shared amongst ES team
18. Employer contact quality	• ES engages employers directly to effectively match roles to clients	
19. Job diversity	• ES accesses different types of jobs	
20. Employer diversity	• ES accesses different types of employers	
21. Focus open employment	• Competitive open employment to matched role is the day one goal	
22. Personalised follow-on supports	• Action plans include in-work support needs • ES supports client and employer through job transition and in-work sustainment	
23. Time-unlimited in-work support	• ES delivers regular in-work support • ES steps down in-work support if viable • Support may in theory be time-unlimited	• ES delivers regular in-work support • ES steps down in-work support if viable • Support time-limited to 12 months max, following evidence from Burns et al. (2015)
24. Community-based services	• ES meets client in accessible private locations out in the community	
25. Assertive outreach	• Assertive outreach engages detached clients	

This is an open access version of the article published in Social Policy and Society (2018) https://doi.org/10.1017/S147474641800043X. To cite the article please use: Whitworth, A (2018) 'Mainstreaming effective employment support for individuals with health conditions: an analytical framework for the effective design of modified Individual and Placement Support (IPS) models', Social Policy and Society. https://doi.org/10.1017/S147474641800043X

Within modified IPS services, however, this key translation task of those modifiable fidelity items is at present being conducted by international policy makers without clear guidance. The significant risk in this context presently is that this on-going uncritical modification of key fidelity items will – whether intentionally or, more likely, unintentionally – undermine the distinctive characteristics and effectiveness of IPS during its attempted translation for mainstream cohorts and needs. This is the analytical and policy problem that serves as a motivation for the discussion that follows. Informed by, but stepping out from, the specifics of this particular modified IPS service codesign and reflecting instead on the broader analytical considerations that emerge from that process, the discussion below offers for the first time in the literature an original and critically reflective analytical framework for the effective design of modified IPS services.

From modified IPS to modified IPSs: developing an analytical framework to guide future policy design

The task that policy makers face with these modifiable fidelity items is to configure the service in the most appropriate ways in order to deliver the intent and ends of each of these items in maximally effective and efficient ways. The modifiable fidelity items highlighted in Table 1 fall into two categories: one set of items that relate to the focus and intensity of the core employment specialists (target cohort, caseload size, and time-limited support) and, once defined, a second set of items that relate to the qualitative (re)configuration of the mode of programme delivery to maximise service user experiences and employment outcomes (IPS employment specialist role in providing whole-person support, integration into health team, employer contact frequency and employer engagement, collaboration with public employment service, senior health system support for IPS and open employment for patients).

Let us turn first to those modifiable fidelity items relating to the focus and intensity of the core employment offer – target cohort, caseload size, and time-limited support. The shift to modified IPS often involves opening open out the target cohort to differing cohorts compared to the traditional IPS emphasis on severe mental health only, as in our trial's focus on low to moderate mental and/or physical health as well as to individuals who may be in-work and off-sick or struggling as well as out-of-work and seeking to move into employment.

Once the target cohort has been defined, a second decision concerns the desired live caseload for each IPS employment specialist – a key driver of core service intensity and also cost. Traditional IPS seeks a highly ambitious caseload of twenty within its fidelity scale. As with traditional IPS fidelity the task within any modified IPS service remains to maximise fidelity on this item via low caseloads. This can however be considered as a modifiable fidelity item so as to signal that for these wider and larger cohorts some slippage in target caseload size (to maximum thirty-five in our codesigned trial for instance) is possible if not expected. To provide some benchmarking context, typical caseload size in the UK context is around one hundred per employment advisor (Considine et al., 2015; WPSC, 2016: 33).

The third modifiable item in this first set relates to time-limited support. Traditional IPS models are in principle time-unlimited, though in practice IPS seek to exit service users from service once their employment transitions are stable. Recent trial evidence suggests that time-limiting IPS services to nine months support delivers similar employment outcomes as a time-

This is an open access version of the article published in Social Policy and Society (2018) https://doi.org/10.1017/S147474641800043X. To cite the article please use: Whitworth, A (2018) 'Mainstreaming effective employment support for individuals with health conditions: an analytical framework for the effective design of modified Individual and Placement Support (IPS) models', Social Policy and Society. https://doi.org/10.1017/S147474641800043X

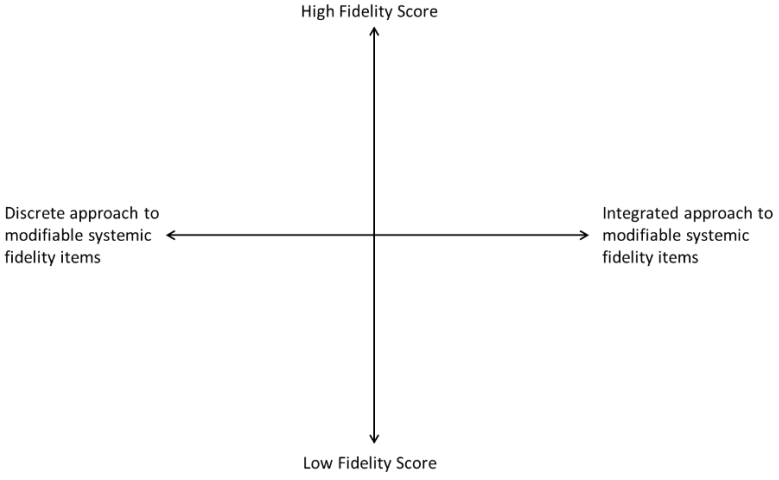
unlimited service but in a significantly more cost-efficient manner (Burns et al., 2015). The expectation is that many modified IPS services will be time-limited in this way in order to seek to optimally balance these financial and performance considerations.

Although these fidelity items may require reconfiguration for modified IPS services their reworking relates more to choices around priority cohorts and budgets that set the parameters within which the more complex design choices – and performance risks – of the modifiable fidelity items occur. Turning to that second set of modifiable fidelity items, of central importance to their effective reconfiguration is the recognition that programme designers can seek to deliver the intent and ends of these items in two radically different ways. One approach can be considered a discrete service approach in which the IPS service and employment specialist have primary responsibility for their delivery within a relatively stand-alone service. In contrast, an alternative model takes a networked service approach in which the IPS service and employment specialist are instead embedded into and required to co-ordinate the utilisation of the wider services, partners and networks of the local health and employment system.

A resulting framework can be presented visually as in Figure 1 to frame analytically a comparative approach to assessing modified IPS services. Along the vertical axis services must strive to reach as high a score as possible on their modified fidelity scale in terms of the quality of their IPS service and its likely effectiveness, just as in traditional IPS. Along the horizontal axis, however, there is recognition that this can be done in qualitatively distinct ways dependent upon the extent of discrete or networked approach in its reconfigured delivery.

Two significant implications fall out. Firstly, local context matters, for what is optimal will vary depending upon a range of programme specific factors – cohort, volumes, priorities, partners, leadership, ambition, existing employment and health context, budgets, and so on. Secondly, and related, there is as a consequence no one 'true' modified IPS model but, instead, potential for multiple different but equal modified IPSs in terms of their fidelity and effectiveness, dependent upon programmatic and contextual specificity – in contrast to the impression of one 'true' high quality model towards which all services should aim in the case of traditional IPS.

Figure 1: Mapping the nature and quality of alternative modified IPSs



This is an open access version of the article published in Social Policy and Society (2018) https://doi.org/10.1017/S147474641800043X. To cite the article please use: Whitworth, A (2018) 'Mainstreaming effective employment support for individuals with health conditions: an analytical framework for the effective design of modified Individual and Placement Support (IPS) models', Social Policy and Society. https://doi.org/10.1017/S147474641800043X

The next section discusses the principal options and considerations for policy designers across these key modifiable fidelity items that are at the heart of critically reflective and context specific qualitative translation of IPS principles and performance into modified IPS services.

In or out?: Networked vs discrete reconfiguration of modifiable fidelity items

By way of illustration to these ideas, Table 2 summarises high-level differences between what alternative discrete and networked approaches to the reconfiguration of these fidelity items. The following sub-sections discuss each in turn in further detail.

Table 2: Discrete and networked approaches to delivering modifiable fidelity items

Modifiable fidelity item	Functional Needs to Deliver	Discrete approach	Networked approach
IPS ES role in ensuring whole-person support	• Health needs delivered • Wider support needs delivered	IPS ES responsible for leading delivery of wider support needs	IPS ES responsible for co-ordinating wider support needs from local services
Integration into health team	• IPS ES integrated into relevant primary care team • IPS ES able to integrate with wider health teams • Appropriate type and volume of referrals	IPS ES only engage with, and receive referrals from, primary care teams integrated into	IPS ES integrated into relevant primary care team, processes enable integration across health teams, and referrals enabled from all relevant sources
Employer contact frequency and employer engagement	• Appropriate type and volume of job opportunities • Personalised support to employers and users for job matching, entry and sustainment •	IPS ES expected to carry out all employer engagement functions for caseload	IPS ES liaises with existing employer engagement teams and vacancy databases to source employment opportunities and leads all employer-individual contact
Collaboration with Public Employment Service (PES) (eg. Jobcentre Plus)	• Appropriate type and volume of referrals • Warm exits back to PES • Satisfaction of any PES conditionality needs	PES and IPS service retain separate norms and processes, and IPS ES delivers any PES needs as best possible	PES and IPS service share norms and processes, and IPS ES works with PES to deliver any PES needs in partnership
Senior Support for IPS and aim of open employment for cohort	• Senior support to do work needed in organisation to launch and run service • Agreed governance for mobilisation, performance management and issues	Senior partners across organisations offer formal support on call-off basis, overlapping agenda remain separate	Senior partners across organisations offer formal support in live partnership and collaboration on overlapping agenda

This is an open access version of the article published in Social Policy and Society (2018) https://doi.org/10.1017/S147474641800043X. To cite the article please use: Whitworth, A (2018) 'Mainstreaming effective employment support for individuals with health conditions: an analytical framework for the effective design of modified Individual and Placement Support (IPS) models', Social Policy and Society. https://doi.org/10.1017/S147474641800043X

Items 10 and 11: Senior support for IPS and for the principle of open employment for the health and disability cohort

The traditional IPS fidelity scale rightly acknowledges the importance of strategic, policy and financial support at senior levels of the health systems that run them. Similar senior support is equally important inside modified IPS services but is more demanding in ideally being required across a wider set of partner organisations, recognising the reach and interaction of modified IPS services to wider elements of the local health and employment systems – health partners still, but also local and regional government partners, public employment services (PES), and third sector too for example.

Yet if it essential to have this senior support across organisations the question remains as to how best to configure it? In the utopian dream of locally integrated employment 'ecosystems' these senior partners might approach their own collaboration in this same networked approach with integrated governance, strategies, commissioning, budgets, targets, and so on. Whilst in principle highly attractive and beneficial, the barriers to this approach are multiple and significant given the reality of differing organizational priorities, activities and governance. Alternatively, therefore, relevant senior partners might formally sign up to supporting the project and agree to collaborate as required on a task and finish basis to overcome blockages, commit necessary operational resources and ensure that the project can be a success, but might not commit to the formulation of shared strategies, policies, governance, budgeting and so on beyond this.

Item 6: Collaboration with the Public Employment Service (PES)

Traditional IPS services within secondary mental health services often involve relatively limited interactions with the PES. A new need in modified IPS services is to strengthen the relationship between the IPS service and the PES in terms both of cohort flows (both referrals and exit handovers) and, with varying importance dependent upon the nature of the national benefits system, ensuring any benefits conditionality requirements are met which individual are on the modified IPS service.

Whilst traditional IPS services emphasise referrals from the same secondary mental health teams in which IPS employment specialists are co-located in modified IPS services the wider system is instead key to referrals. Discussed below, wider primary care health services are of relevance. So too however are the nation's PES given that many eligible participants will be in receipt of social security benefits and attending meetings at their PES to check on-going benefit eligibility and/or receive employment support. It is sensible in modified IPS services therefore to encourage and enable referrals from PES to modified IPS services, and similarly to facilitate warm handovers with assessment and intervention notes from the IPS service back to PES as appropriate where employment outcomes are not achieved and a return to PES occurs.

In terms of conditionality, there is a key need to ensure that individuals inside these voluntary modified IPS schemes continue to satisfy any PES conditionality requirements such that they avoid sanctions and continue to be eligible for social security benefits whilst participating in modified IPS rather than PES employment support. These conditionality needs require close attention within modified IPS services given that a significant part of their wider mainstream cohorts will continue to face such conditionality requirements, opening up

potentially significant financial risks for participating low income service users. The importance of this need will inevitably vary by context dependent both upon the cohort's level of social security receipt and the nature of the conditionality and sanctions regimes in operation in that country or locality. Whether this need can be handled in a networked way via seamless data flows or – as in the UK context – instead via new clerical processes of evidence creation and sharing between the modifies IPS service and PES will be case specific and depend on the legal, technical and relational contexts of particular services.

Item 4: Integration into health teams

Integration remains a critical feature to the effectiveness of IPS programmes but requires systemic reconfiguration in modified IPS services in relation both to appropriate host heath teams and referral sources. Likely host teams for IPS employment specialists in modified services include primary care services for mental health, physio and pain management teams, community hubs and GP practices. In a discrete approach to modifying this item the host primary care team would be the health 'universe' in which the individual's support was considered and provided. A networked approach would in contrast recognise the frequent comorbidity of different health conditions for a significant proportion of any health cohort and establish expectations and processes to enable IPS employment specialist integrated into one team relating to the primary health condition of the individual – a primary care mental health team for instance – to work effectively with another primary care team – pain management for instance – as required to offer whole-person healthcare support to their caseload. Alongside PES, all such primary care teams into which IPS employment specialists are integrated are naturally expected and enabled to refer into the modified IPS service, alongside wider parts of the health system potentially such as pharmacies, community health teams and social prescribing services for example.

Items 2 and 17: IPS services staff role in ensuring whole-person support and employer engagement

In modified IPS services the same three key functions as in traditional IPS services still need to be delivered: personalised and intensive employability support to individuals; delivery of health and wider (e.g. housing, debt, family, travel) support needs; and personalised employer engagement to enable effective job matching, entry and sustainment for individuals and employers. Whilst traditional IPS services themselves deliver all three, and whilst IPS employment specialists in modified IPS services naturally retain responsibility for delivery of personalised employment support to individuals, there is both a capacity consideration and a system opportunity (alignment, effectiveness, efficiency, simplicity) to consideration of a networked approach to the delivery of employment engagement and wider support needs.

On the supply-side individuals will require supports for both health conditions and a range of wider support needs (e.g. housing, finances, skills, family). In terms of health supports, existing mental health and physical health primary care services are key, but are not always most appropriate for every individual's needs and are facing significant demand pressures in many contexts that affect eligibility and waiting times. One possible expansion of IPS employment specialist's roles in modified IPS services would be to become trained in the types of low-level

mental and physical health needs that will be common across their caseloads – cognitive behavioural therapy (CBT), physio and pain management for example. When conceived across a team of IPS employment specialists this range of skill sets, combined with clear training and guidance around how to practice and when it is appropriate to instead refer up to more specialist and/or intensive services, could be a helpful addition to ensuring timely and appropriate health support to service users. The risk would be to divert the time and expertise of IPS specialists away from the dedicated employment focus as in a traditional IPS model and it would therefore be important to assess empirically the effectiveness of any such role bend.

There is similarly a question about how best to deliver individual's wider support needs in a context where needs vary, appropriate local services already exist, and caseloads are by financial necessity inevitably somewhat higher than in traditional IPS services. A discrete approach in which IPS employment specialists in modified IPS services are expected to deliver these wider support services themselves may be neither realistic nor desirable. Instead, networked approaches that draw on existing wider expertise and resources across the wider local system outside of the modified IPS service itself may be attractive. Indeed, local areas could help modified IPS services to deliver this function through formalised governance mechanisms to co-ordinate such wider support services – Local Integration Boards as they are coming to be known in several UK city-regions.

Similar considerations are apparent on the demand-side where it is possible to separate out key employer engagement functions around identification and proactive cultivation of suitable vacancies from individual-level discussion and brokerage with employers and service users to build relationships, understand needs, and support job transitions, adaptations and on-going sustainment. Within traditional IPS models the IPS employment specialist is responsible for both functions and whilst this may be replicated in modified IPS services more networked approaches may again be more realistic and/or desirable. It is possible that the initial function of large-scale aggregate initial employer engagement to source opportunities be led by existing (e.g. local authority) employer engagement teams outside of the modified IPS service itself but with an eye to the needs of its service users. These wider employer engagement teams could then communicate opportunities to the modified IPS service and broker introductions between employers and IPS workers. All individual-level work with and between employers and service users can then continue to be delivered by IPS employment specialists, as in traditional IPS models. Unlike the more aggregate-level functions around identifying initial opportunities, it is these individual-level relationally based functional needs around understanding job roles and needs, brokering job matches and work transitions, arranging workplace and/or role adaptation and providing on-going support in work support where focusing the time and energy of IPS employment specialists in modified services can really add value.

Stepping back and moving forwards: realising the potential of modified IPS

Transforming the employment support experiences and outcomes for individuals with health conditions and disabilities is an essential part of a broader set of changes in societies and labour markets if nations are to begin to make meaningful inroads into the entrenched disability employment gaps than span advanced economies. IPS services have a proven track record of effectiveness with a severe mental health cohort in secondary mental health settings and

modified IPS services present significant potential in the larger, wider health cohorts in primary and community care settings that will be key to narrowing the gap. Based on the validated and well-evidenced principles, fidelity and performance of traditional IPS services internationally, this article has argued that well-considered, critically reflexive modification of IPS can and should offer a solid foundation on which to build more effective employment programmes for other wider types of health conditions and severities and, indeed, cohorts more broadly.

The article outlines however that a significant translation gap from traditional to modified IPS models exists at present and that this creates on-going barriers and risks around the design and resultant performance of such modified IPS services. This article's critically reflexive discussion of IPS modification and its presentation for the first time in the international literature of an original analytical framework to guide policy makers through a well-considered process of IPS modification offer powerful contributions in this context. Four specific contributions can be identified.

Firstly, the article differentiates for the first time in the literature between what we term standard fidelity items that programme designers of modified IPS services ought simply to maximise in the same manner as traditional IPS services versus modifiable fidelity items whose configurations might appropriately require qualitatively reconfiguration in order to deliver optimally the desired intent and ends of the fidelity item.

Secondly, the discussion highlights that most items of the traditional IPS fidelity scale can indeed be understood as standard fidelity items that apply equally to larger mainstreamed modified IPS services to a broader health cohort. This is an important finding in terms of the flexible potential of modified IPS model to effectively support a far larger share of the total health-related employment challenge across advanced economies. Central to why is the recognition that the IPS fidelity scale and principles outlined above are in significant part expressions simply of what good employment support could and should look like for everybody, irrespective of whether they have a health condition. This is in contrast to the frequent view of IPS as some sort of different and special employment model for particular health cohorts and, critically, indicates that modified IPS models have significant wider potential beyond a health cohort to which is it almost always discussed exclusively. Yet beyond the small and self-contained bubble of traditional IPS this is often not what mainstream employment support for individuals with health conditions looks like across the advanced economies however. Indeed, countries such as the UK display a 'low road' employment support model comprising a highly limited employment offer to individuals with health conditions and disabilities in terms of its coverage, intensity and resources combined with an emphasis on low-cost behaviouralistic mandation and sanctions (Eleveld, 2017; Fletcher and Wright, 2017) – the near complete antithesis of the solid evidence base around what works to grow levels of employment, incomes and wellbeing for individuals with health conditions and disabilities.

Thirdly, the necessary reconfiguration of several key modifiable fidelity items can be approached in what we term either a networked or discrete manner, with decisions needing to be considered carefully based on the nature of the wider local services and system as well as the needs, priorities and resources of the modified IPS service. As a consequence, and quite unlike the situation with traditional IPS services, variability in the design of modified IPS services

dependent upon programme and local context is both possible and perfectly appropriate, meaning no one 'true' modified IPS service exists for all contexts.

Finally, the article brings these ideas together within the presentation of an original analytical framework to help policy makers to develop effective modified IPS services in a structured, well-considered and critically reflective in their particular programmes and local contexts. It is hoped that this will help analysts and policy colleagues to make more effective design decisions in their particular modified IPS programmes by filling the current translation gap and associated programme risks around the appropriate sharing and modification of IPS principles and fidelity items. It remains the case that such modified IPS interventions will require the same attention to the evaluation of their fidelity and performance as seen in the traditional IPS literature in order that we can grow a similarly robust evidence base about their performance and optimisation. For if we are to make the much-needed step-change in employment support experiences and outcomes across advanced economies it is important that scholars and policy makers alike engage seriously with the solid evidence of IPS services and the growing evidence and analytical thinking around the potential of well-considered modified IPS services, of which this present article has sought to contribute. Only then can we hope to design the types of employment support programmes that will give us the transformative change in outcomes that we want and need, and the types of support that our citizens deserve.

References

Bond, G., Becker, D., Drake, R. and Vogler, K. (1997) 'A fidelity scale for the Individual Placement and Support model of supported employment', Rehabilitation Counselling Bulletin, 40(4), 265-284

Bond, G., Campbell, K., Evans, L., Gervey, R., Pascaris, A., Tice, S., Del Bene, D. and Revell, G (2002) 'A scale to measure quality of supported employment for persons with severe mental illness', Journal of Vocational Rehabilitation, 17, 239-250

Bond, G., Drake, R. and Becker, D. (2008) 'An update on randomized controlled trials of evidence-based supported employment', Psychiatric Rehabilitation Journal, 31, 4, 280-290.

Bond, G., Becker, D. and Drake, R. (2011) 'Measurement of fidelity of implementation of evidence-based practices: case example of the IPS fidelity scale', Clinical Psychology Science and Practice, 18, 126-141

Bond, G., Drake, R. and Becker, D. (2012a) 'Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US', World Psychiatry, 11(1), 32-39

Bond, G., Peterson, A., Becker, D. and Drake, R. (2012b) 'Validation of the Individual Placement and Support fidelity scale (IPS-25)', Psychiatric Services, 63(8), 758-763

Burns, T. and Catty, J. (2008) 'IPS in Europe: the EQOLISE trial', Psychiatric Rehabilitation Journal, 31, 4, 313-317.

Burns, T., Yeeles, K., Langford, O., Vazquez Montes, A. and Burgess, J. (2015) 'A randomised controlled trial of time-limited individual placement and support: IPS-LITE trial', The British Journal of Psychiatry, 207, 351-356.

Campbell, K., Bond, G. and Drake, R (2010) 'Client predictors of employment outcomes in high-fidelity supported employment', The Journal of Nervous and Mental Disease, 198(8), 556-563

Centre for Mental Health. (2015) The IPS Fidelity Scale, https://www.centreformentalhealth.org.uk/the-ips-fidelity-scale [accessed 13.09.2016]

Considine, M., Lewis, J., O'Sullivan, S. and Sol, E. (2015) Getting welfare to work: street-level governance in Australia, the UK and the Netherlands. Oxford: Oxford University Press.

Coole, C., Drummond, A. and Watson, P. (2013) 'Individual work support for employed patients with low back pain: a randomized controlled pilot trial', Clinical Rehabilitation, 27(1), 40-50

Department for Work and Pensions-Department of Health (DWP-DH). (2016) Work, health and disability Green Paper Data Pack, Technical Annex, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/644090/work-health-and-disability-green-paper-data-pack.pdf [accessed 24.01.2017]

Dolan, P., Peasgood, T. and White, M. (2008) 'Do we really know what makes us happy? A review of the economic literature on the factors associated with subjective well-being', Journal of Economic Psychology, 29, 94-122.

Eleveld, A. (2017) 'Activation policies: policies of social inclusion or social exclusion?', Journal of Poverty and Social Justice, 25, 3, 277-85.

Ellison, M., Klodnick, V., Bond, G., Krzos, I., Kaiser, S., Fagan, M., and Davis, M. (2015) 'Adapting supported employment for emerging adults with serious mental health conditions', The Journal of Behavioral Health Services and Research, 42(2), 206-222

Eurostat (2018) Disability Statistics – Employment Patterns http://ec.europa.eu/eurostat/statistics-explained/index.php?title=Disability_statistics_-_employment_patterns [accessed 8th August 2018]

Ferguson, K., Xie, B. and Glynn, S. (2012) 'Adapting the individual placement and support model with homeless young adults', Child Youth Care Forum, 41, 277-294

Fletcher, D. and Wright, S. (2017) 'A hand up or a slap down? Criminalising benefit claimants in Britain via strategies of surveillance, sanctions and deterrence', Critical Social Policy, doi: /10.1177/0261018317726622

Kim, S., Bond, G., Becker, D., Swanson, S. and Langfitt-Reese, S (2015) 'Predictive validity of the Individual Placement and Support fidelity scale (IPS-25): A replication study', Journal of Vocational Rehabilitation, 43, 209-216

Li-Tsang, C., Li, E., Lam, C., Hui, K. and Chan, C. (2008) 'The effect of a job placement and support program for workers with musculoskeletal injuries: a randomized control trial (RCT) study', Journal of Occupational Rehabilitation, 18(3), 299-306.

Lockett, H., Waghorn, G., Kydd, R. and Chant, D. (2016), 'Predictive validity of evidence-based practices in supported employment: a systemtic review and meta-analysis', Mental Health Review Journal, 21(4), 261-281

Luciano, A., Drake, R., Bond, G., Becker, D., Carpenter-Song, E., Lord, S., Swarbrick, P. and Swanson, S (2014) 'Evidence-based supported employment for people with severe mental illness: past, current, and future research', Journal of Vocational Rehabilitation, 40, 1-13

Margolies, P., Humensky, J., Chiang, I., Covell, N., Broadway-Wilson-K., Gregory, R., Jewell, T., Scannevin, G., Baker, S. and Dixon, L. (2017) 'Is there a role for fidelity self-assessment in the Individual Placement and Support model of supported employment?', Psychiatric Services, 68(9), 975-978

Margolies, P., Humensky, J., Chiang, I., Covell, N., Jewell, T., Broadway-Wilson, K., Gregory, R., Scannevin, G. and Dixon, L (2018) 'Relationship between self-assessed fidelity and self-reported employment in the Individual Placement and Support model of supported employment', Psychiatric Services, 69(5), 609-612

Marshall, T., Goldberg, R., Braude, L., Dougherty, R., Daniels, A., Shom Ghose, S., George, P. and Delphin-Rittmon, M (2014) 'Supported employment: assessing the evidence, Psychiatric Services, 65(1), 16-23

McGrew, J and Griss, M (2005) 'Concurrent and predictive validity of two scales to assess the fidelity of implementation of supported employment', Psychiatric Rehabilitation Journal, 29(1), 41-47

McGurk, S., Twamley, E., Sitzer, D, McHugo, G. and Muser, K. (2007) 'A meta-analysis of cognitive remediation in schizophrenia', American Journal of Psychiatry, 164, 1791-1802

Metcalfe, J., Drake, R. and Bond, G. (2018) 'Economic, labor and regulatory moderators of the effect of Individual Placement and Support among people with severe mental illness: A systematic review and meta-analysis', Schizophrenia Bulletin, 44(1), 22-31

Modini, M., Tan, L., Brinchmann, B., Wang, MJ., Killackey, E., Glozier, N., Mykletun, A. and Harvey, S. (2016) 'Supported employment for people with severe mental illness: systematic review and meta-analysis of the international evidence', The British Journal of Psychiatry, 209, 1, 1-9

Mowbray, C., Holter, M., Teague, G. and Bybee, D. (2003) 'Fidelity criteria: development, measurement, and validation', American Journal of Evaluation, 24(3), 315-340

Mueser, K., Drake, R. and Bond, G. (2016) 'Recent advances in supported employment for people with serious mental illness', Current Opinion in Psychiatry, 29, 196-201.

OECD (2015) Fit Mind, Fit Job: From evidence to practice in mental health and work, Mental Health and Work. Paris: OECD Publishing.

Oguz, S., Merad, S. and Snape, D. (2013) Measuring national well-being – what matters most to personal well-being? London: Office for National Statistics.

Paulson, R., Post, R., Herinckx, H. and Risser, P. (2002) 'Beyond components: using fidelity scales to measure and assure choice in program implementation and quality assurance', Community Mental Health Journal, 38(2), 119-128

Poremski, D., Rabouin, D. and Latimer, E. (2017) 'A randomised controlled trial of evidence based supoted employment for people who have recently been homeless and have a mental illness', Administration and Policy in Mental Health, 44, 217-224

Smith, D., Atmatzidis, K., Capogreco, M., Lloyd-Randolfi, D. and Seman, V (2017) 'Evidence-based interventions for increasing work participation for persons with various disabilities: A systematic review', OTJR: Occupation, Participation and Health, 37(25), 3S-13S

Suijkerbuijk, Y., Schaafsma, F., van Mechelen, J., Ojajarvi, A., Corbiere, M. and Anema, J. (2017) 'Interventions for obtaining and maintaining employment in adults with severe

mental illness, a network meta-analysis', Cohrane Database of Systematic Reviews 2017, 9, doi: 10.1002/14651858.CD011867.pub2

Sveinsdottir, V., Løvvik, C., Fyhn, T., Monstad, K., Ludvigsen, K., Øverland, S. and Reme, S. (2014) 'Protocol for the effect evaluation of Individual Placement and Support (IPS): a randomized controlled multicenter trial of IPS versus treatment as usual for patients with moderate to severe mental illness in Norway', BMC Psychiatry, 14: 307

Van Stolk, C., Hofman, J., Hafner, M. and Janta, B. (2014) Psychological wellbeing and work: improving service provision and outcomes. London: Department for Work and Pensions and Department of Health, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273433/psychological-wellbeing-and-work.pdf [accessed 12.03.2017]

Waddell, G. and Burton, K. (2006) Is work good for your health and wellbeing? An independent review. London: The Stationery Office, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf [accessed 22.05.2017]

Work and Pensions Select Committee (WPSC). (2016) The future of Jobcentre Plus: Second report of session 2016-17, HC57. London: House of Commons, https://publications.parliament.uk/pa/cm201617/cmselect/cmworpen/57/5702.htm [accessed 04.02.2017]

Work and Pensions Select Committee (WPSC). (2017) Disability employment gap: Seventh report of session 2016-17, HC56. London: House of Commons, https://publications.parliament.uk/pa/cm201617/cmselect/cmworpen/56/56.pdf [accessed 16.03.2017]