STEPS INTO WORK

Integrating Employment and Mental Health Supports Project Final Report

Mental Health Reform
Promoting Improved Mental Health Services

Mental Health **Reform**

Promoting Improved Mental Health Services

IEMHS Project Steering Committee

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Introduction

Introduction

Individual Placement and Support (IPS), also known as 'evidence-based supported employment', is a model that facilitates people with mental health difficulties to move into mainstream competitive employment. Under the IPS model, anyone is viewed as capable of undertaking competitive paid work in the community, if the right kind of job and work environment can be found and the right support is provided. IPS is a variant of the Supported Employment approach, although it differs from other forms of Supported Employment in a number of key ways:

- IPS is focused more towards people with severe and enduring mental health difficulties
- IPS offers long term support for as long as an individual needs it,
- The Employment Specialists (ES) who are central to this programme are integrated into mental health teams to support service users to return to work. These employment specialists may be employed by the State or a third party specialist provider.[1]

The IPS model involves eight key principles:

1. Competitive employment is the primary goal
2. Everyone who wants to work is eligible for employment support
3. Participants are helped to look for work which suits their preferences and strengths
4. Job search and contact with employers begins quickly - within four weeks
5. Employment specialists are based within clinical teams, and work with the team to support people to find paid employment
6. Support is ongoing and arranged to suit both the employee and employer
7. Benefits advice is given as part of the return to work
8. Strong relationships are built with employers

Current services in Ireland

In Ireland currently, EmployAbility companies provide employment support services on behalf of the Department of Employment Affairs and Social Protection (DEASP) to people with disabilities, including those with mental health difficulties, to help them access employment. Each local EmployAbility service operates as an independent company with its own Board and management,

[1] http://www.amh.org.uk/wp-content/uploads/2010/06/IPSBookletA4-Proof-2.pdf

though wholly funded by the DEASP. Each EmployAbility service operates to annual targets set by the DEASP and framed within an annual funding and performance agreement.

EmployAbility services provide a number of pre-vocational and on-the-job supports, such as vocational assessments and Job Coaches who assist both the employer and the person seeking employment. EmployAbility services use a Supported Employment model which differs form a pure IPS approach.

Under the current EmployAbility programme, for example, individuals who wish to access the service are required to meet the 'job ready' criteria, which is defined as:

> "Having the necessary training, motivation, education and ability to progress to work and pursue work/career in the open labour market; willing and able (with support) to work at least eight hours per week in open employment; and having the required training and education for their chosen career."[2]

The EmployAbility programme is also a time-limited service, to a maximum duration of eighteen months' support, unlike IPS which offers support indefinitely.

Integrating Employment and Mental Health Support (IEMHS) pilot project

Integrating Employment and Mental Health Support (IEMHS) is a pilot project developed with Genio and Department of Employment Affairs and Social Protection (DEASP) funding and in partnership with the Health Service Executive (HSE) Mental Health Division, Department of Employment Affairs and Social Protection, EmployAbility companies and Mental Health Reform. The IEMHS project piloted the IPS model by integrating an EmployAbility Employment Specialist into each of four Multidisciplinary Mental Health Teams (MDTs), in order to deliver an IPS service in four sites across Ireland. Mental Health Reform's role during the project was to provide project management and evaluation.

Project aims & objectives

The overall aim of the IEMHS project was:

> To demonstrate how existing mental health and supported employment (EmployAbility) services can fulfil the best practice Individual Placement and Support (IPS) model of supported employment through improved integration with mental health services.

[2] Indecon (2016) Evaluation of the Employability (Supported Employment) Service, Department of Social Protection available at http://www.welfare.ie/en/downloads/IndeconEvaluationofEmployAbility.pdf, p.47.

A central objective of the IEMHS project was to improve integration between public mental health and supported employment services at national and local levels. These two services are the responsibility of two different government departments (the Department of Health and the Department of Employment Affairs and Social Protection) and involve different public agencies (the Health Service Executive, a national agency, and EmployAbility services which are organised at local level). The two services have different funding streams, regulations, management structures and governance systems. A significant part of the IEMHS project involved a proof of concept that an integrated service involving joint working between public agencies is possible in the Irish context.

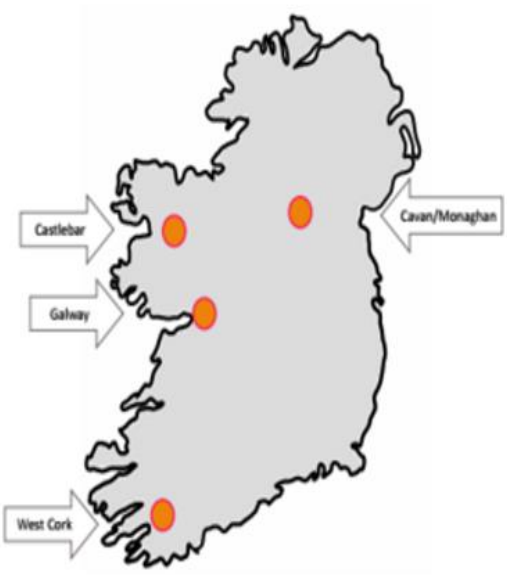
The specific objectives of the project were:

1. To improve integration between public mental health and supported employment services at national level.
2. To improve integration between public mental health and supported employment services at local level.
3. To support 80 individuals receiving mental health services into employment, 20 individuals in each of 4 sites.
4. To increase the capacity of participating supported employment service staff and mental health service staff to support individuals with severe mental health difficulties.

Project sites

The IEMHS project was carried out across four sites. These sites were selected on the basis of both an EmployAbility service and a local mental health service signalling their interest in participating. The four sites selected were Cavan/Monaghan, Castlebar in County Mayo, Galway and Bantry in West Cork. The locations of these sites can be seen in the map below. A detailed description of each site will be provided in a subsequent section.

Location of the IEMHS pilot project sites



Target group

The target group for the IEMHS project was adults with severe and enduring mental health difficulties who were not in paid competitive employment. The criterion used for defining severe mental health difficulties was 'any person who was attending a secondary or specialist mental health service'.

The project aimed to work with individuals who were receiving support from an MDT and who could potentially be referred to an EmployAbility service on the basis of having a need for supported employment alongside a severe mental health difficulty.

It should be noted that individuals using community mental health services may regularly attend a day hospital, day centre, clubhouse (e.g. EVE clubhouses), sheltered workshop, or rehabilitative or vocational training centre (e.g. National Learning Network). A proportion of long-term mental health service users also reside in HSE supported accommodation. They may receive occupational therapy and other supports from their Community Mental Health Team (CMHT) or Rehabilitation & Recovery team. Some mental health service users may also have been receiving support from an EmployAbility job coach.

Project timeline

A Steering Committee for the project was established in late 2014, which included representatives from each of the key stakeholders: HSE, DEASP, MHR, and the Department of Health. (A representative from EmployAbility Services joined the Steering Committee later). Significant project

preparation took place before the official start date in June, 2015. Steering Committee meetings took place from January to April 2015, during which time a project plan was developed. During this time a primary activity was recruitment of the Employment Specialists. It was not possible to begin the project until all four job coaches were in place.

In June 2015, comprehensive IPS training was delivered to each site team by the international IPS experts, Implementing Recovery through Organisational Change (IMROC), who provided a three-day training programme. Each IPS site team that was trained included MDT members, an Employment Specialist, and an Employment Coordinator from the EmployAbility service (Except in the case of Castelbar), who provided supervision to the Employment Specialist. IEMHS project management staff also participated in the IPS training.

Shortly after the training, IMROC provided a one-day planning session to the sites to discuss local implementation issues in detail. Three of the sites participated together in one of the planning sessions (Castlebar, Cavan/Monaghan and Galway) and West Cork had a separate planning day.

Between September and October 2015 a project evaluation plan was developed with the Steering Committee after consultation with the site teams.

Given the constraints of data protection legislation and confidentiality ethics procedures, before recruitment of project participants could take place, significant work was undertaken to establish an inter-agency data sharing protocol. The data sharing protocol enabled Employment Specialists to be integrated into MDTs and have access to mental health service users' clinical files. These agreements were also needed so that Employment Specialists and MDTs could be co-located, which is central to the IPS model. Agreements were reached at each site by establishing a formal Data Sharing Agreement between the local EmployAbility service and the HSE in that area, and support on this issue was also provided by the HSE Mental Health Division centrally and the Office of the Data Protection Commissioner. An example of these protocols can be found in the Appendix. Formal Data Sharing Agreements were in place in all sites by February, 2016.

The first participants for the project began to be recruited in Galway, Bantry and Cavan/Monaghan in late August, 2015 and in February, 2016 in Castlebar. Recruitment continued through to the end of December 2016.

Learning Sets, which functioned as debriefing and training sessions for all of the site teams, took place in October 2015, March 2016, October 2016 and June 2017. Three of the Learning Sets were attended by external IPS experts who were able to offer input into challenges that emerged in each project site. Due to the particular responsibilities of the Employment Specialists in the project,

support was organised for them between Learning Sets. Conference calls with Employment Specialists and external advisers took place throughout the project to give Employment Specialists an opportunity for continued support and networking.

In March 2016 and March 2017, each project site was evaluated under the IPS Fidelity Evaluation Scale (Fidelity Scale). The Fidelity Scale translates the 8 key principles of IPS into 25 items that a service can be scored against. The higher the score, the greater the quality of the IPS service and the higher the expected job outcomes. The Fidelity Evaluations were conducted by Mental Health Reform with external oversight from IMROC.

Governance

A project plan for the IEMHS project was agreed with the site teams and Steering Committee by April 2015 and a corresponding evaluation plan by October, 2015. The IEMHS project Steering Committee met throughout 2015 and 2016 to discuss the progress of the project. In November 2016, the Steering Committee began discussion around the sustainability of the IEMHS approach to the IPS model in Ireland and the follow-on support for participants. Table 1 displays a Gantt chart that formed part of the project plan for the IEMHS project.

Mental Health Reform provided project management for the IEMHS and was responsible for reporting to funders and key stakeholders.

Table 1

IEMHS Project Gantt chart													
Task	**Jun-15**	**Aug-15**	**Oct-15**	**Dec-15**	**Feb-16**	**Mar-16**	**Jun-16**	**Oct-16**	**Dec-16**	**Feb-17**	**Mar-17**	**Apr-17**	**May-17**
Job coach training													
Site planning													
Recruit participants													
Support participants													
Learning sets													
Fidelity evaluation													
Costing													
Participant focus groups													
Final report													
Sustainability planning													
Steering Group meetings													
Monitoring & reporting to funder	→	→	→	→	→	→	→	→	→	→	→	→	→

Economic and policy context

National policy framework

The importance of employment for people with mental health difficulties has been acknowledged in Irish policy for quite some time.

A Vision for Change (AVFC), the national mental health policy states that "access to employment…..for individuals with mental health problems should be on the same basis as every other citizen".[3] The Expert Group on AVFC recognised that in order to achieve a recovery-orientated mental health system, whereby individuals can live a full life in their community, "supportive communities [are necessary] where actions are taken to address basic needs such as employment".[4]

This is further endorsed in a detailed report on mental health and social inclusion, in which the National Economic and Social Forum (NESF) in Ireland concluded that work is the best route to recovery and employment is the best protection against social exclusion.[5]

A Vision for Change specifically recommended that "evidence-based approaches to training and employment for people with mental health problems should be adopted…".[6] Furthermore, "the development of formal coordination structures between health services and employment agencies should be a priority if the delivery of seamless services is to be facilitated".[7]

Moving forward, the newly established Oversight Group on the development of a new mental health policy for Ireland has identified social inclusion, including employment, as a key focus of its work.

A number of national policies and strategies have recently been published, which include commitments to improving the employment outcomes of people with (mental health) disabilities. The Comprehensive Employment Strategy (CES) for People with Disabilities is aimed at improving employment participation and outcomes for people with disabilities. In particular, the CES includes an action to "promote and support the role of work in the recovery model…for those with mental health difficulties and to "use the Individual Placement Support Model as part of this [recovery]

[3] Department of Health (2006) *A Vision for Change*, p. 35.
[4] Ibid, p.41.
[5] National Economic and Social Forum (2007*) Mental Health and Social Inclusion*, Dublin: National Economic and Social Forum.
[6] Department of Health (2006), p.39.
[7] Ibid, p.111.

process".[8] The CES is complemented by the establishment of an interdepartmental group, under independent chairmanship to effectively monitor the implementation of the strategy.

The National Disability Inclusion Strategy (NDIS) 2017 – 2021, launched in July 2017, further emphasises the need to address unemployment among people with (mental health) disabilities. The strategy includes commitments to ensure that people with (mental health) disabilities are financially better off in work, in line with the recommendations of the *Make Work Pay for People with Disabilities* report (published in April 2017). The NDIS also includes measures to ensure that employers can easily access information about employing a person with a disability and commits to fully implement the Comprehensive Employment Strategy for persons with disabilities

International legal and policy framework

The right of people with (mental health) disabilities to work, on an equal basis with others, is fully enshrined in the UN Convention of the Rights of Persons with Disabilities (UNCRPD). As specified in Article 27 of the Convention, state parties 'shall safeguard and promote the realisation of the right to work'. [9]

In addition to the UNCRPD, the World Health Organisation's World Report on Disability, the EU Disability Strategy and the OECD all emphasise the importance of raising employment rates for people with disabilities.

In particular, the OECD has identified the high costs of mental health difficulties, not only to the individual, but also to the employer and the economy. The Healthy Ireland Framework reports that the economic cost of mental health problems in Ireland is €11 billion per year, much of which is related to loss of productivity in the labour market.[10] A recent report commissioned for the Prime Minister in the UK calculated that workplace mental health difficulties are costing the UK economy up to £99 Billion per annum.[11]

[8] 1 Government of Ireland (2015) Comprehensive Employment Strategy for People with Disabilities 2015-2024, Dublin: Government of Ireland, p. 57.
[9] UN General Assembly, Convention on the Rights of Persons with Disabilities: resolution/adopted by the General Assembly, 24 January 2007, A/RES/61/106, available at http://www.refworld.org/docid/45f973632.html [accessed 17 March 2016].
[10] In 2008, it was identified that mental health difficulties cost the Irish economy around €3 billion or 2% of GNP annually, with most of the costs in the labour market as a result of lost employment, absenteeism, lost productivity and premature retirement.
[11] Department of Work and Pensions (UK (2017) Thriving at Work: The Stevenson/Farmer review of mental health and employers, available at https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers

The OECD recognises that, in order to address such costs, mental health difficulties must become a priority for the employment sector and every branch of social policy, including unemployment and disability.[12] The OECD recommends an integrated approach whereby sectors, services and professionals operating outside of specialist mental health services have a key role to play in improving the employment outcomes of people with mental health difficulties.

The OECD Mental Health and Work Policy Framework provides a series of general policy conclusions for all OECD countries, including recommendations to:[13]

- strive for an employment orientated mental health care system
- improve workplace policies and employer supports and incentives
- make benefits and employment services fit for people with mental health difficulties

Current landscape

Despite commitments across national and international policy and law to ensure people with (mental health) disabilities are supported to both seek and sustain employment, the reality on the ground in Ireland is that such supports are relatively underdeveloped.

The current system of employment supports for people with mental health disabilities throughout the country has manifestly failed to facilitate access to work. People with a mental health disability are nine times more likely to be out of the labour force than those of working age without a disability, the highest rate for any disability group in Ireland.[14] The Department of Employment Affairs and Social Protection's (DEASP) 2015 survey of Disability Allowance (DA) recipients found that 50% of participants reported mental health difficulties as the primary reason for being on Disability Allowance.[15]

Despite such high unemployment rates, half of adults with a mental health disability who are not at work say they would be interested in starting employment if the circumstances were right.[16] The DEASP's Disability Allowance Survey also identifies significant levels of interest among individuals on DA in taking up employment (including both part-time and full-time work). Among those who were

[12] OECD (2015) Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work, Mental Health and Work, Paris: OECD Publishing.
[13] OECD (2015) OECD High-Level Policy Forum on Mental Health and Work Bridging Employment and Health Policies. Paris: OECD Publishing.
[14] Watson, D., Kingston, G. and McGinnity, F. (2012) Disability in the Irish Labour Market: Evidence from the QNHS Equality Module, Dublin: Equality Authority/Economic and Social Research Institute, p. 19.
[15] Judge, C., Rossi, E., Hardiman, S. and Oman, C. (2016) Department of Social Protection Report on Disability Allowance Survey 2015, Dublin: Department of Social Protection.
[16] CSO National Disability Survey 2006 – Volume 2, Dublin: The Stationery Office, p. 86.

not currently working, 35% expressed an interest in working part-time, while a further 8% expressed an interest in full-time employment, given the right supports.[17]

The DEASP's Disability Allowance Survey also identified that people with (mental health) disabilities experience numerous barriers to employment and that a range of supports are required to help achieve employment ambitions and goals, including in areas such as supportive work environments, access to transport, mental health supports, adaptation of job tasks, flexible hours and flexible work arrangements and most importantly retention of the medical card and other social welfare payments.[18,19]

Employment supports for people with disabilities

DEASP provide the following supports for people with disabilities:

Disability Allowance Employment Disregard

A person who is in receipt of Disability Allowance may take up employment. The first €120 of weekly earnings is disregarded in means testing for the payment while earnings between €120 and €350 per week are assessed at 50%.

Partial Capacity Benefit

Partial Capacity Benefit (PCB) is a scheme designed for people who have some capacity for work. If awarded, PCB will allow them to continue to receive a percentage of their Illness Benefit or Invalidity Pension payment while working. Participation in the PCB scheme is voluntary. Participating individuals must be in receipt of either Invalidity Pension or Illness Benefit. Illness Benefit must be paid for at least six months at the date of application for PCB (the six months does not apply to Invalidity Pension). The rate of payment will depend on the personal rate of the qualifying scheme from which the customer originates and the medical assessment of the customer's capacity for work as outlined below.

[17] Judge, C., Rossi, E., Hardiman, S. and Oman, C. (2016) Department of Social Protection Report on Disability Allowance Survey 2015, Dublin: Department of Social Protection.
[18] Ibid.
[19] The recent publication of the Make Work Pay for People with Disabilities report documents that "the potential loss of the Medical Card [has been reported] as the single most important disincentive to taking up employment". The report further identifies that "Ireland (along with the US) appears to be unusual amongst OECD countries in that people must forfeit entitlements to free medical care on taking up work, which occurs at relatively low levels of income". The OECD's Report (2015) Breaking the Barriers: A Synthesis of Findings Across OECD Countries argued that health and other entitlements related to a person's disability should not be affected by benefit or labour market status.

Medical Assessment	% of Illness Benefit or Invalidity Pension personal rate
Moderate	50%
Severe	75%
Profound	100%

Wage Subsidy Scheme

The Wage Subsidy Scheme (WSS) is an employment support to the private sector for the employment of people with disabilities. The purpose of this demand - led programme is to increase the numbers of people with disabilities participating in the open labour market and to encourage employers to hire people with disabilities.

The subsidy is incentivised under three strands, based on the number of employees with a disability engaged. The employer can benefit from one or all, simultaneously depending on the number of employees with a disability recruited by the employer under the scheme.

To participate on the scheme an employee must work a minimum of 21 hours per week up to a maximum of 39 hours per week. The rate of subsidy is €5.30 per hour and is based on the number of hours worked, giving a total annual subsidy available of €10,748 per annum based on 39-hour week.

Evidence base practice

There is strong evidence that the internationally recognised approach to supported employment (Individual Placement and Support or IPS) is the most effective method of supporting individuals with severe and enduring mental health difficulties to achieve sustainable, competitive employment.[20] IPS has also been shown to be both cost effective and less costly than traditional vocational approaches.[21]

[20] Sixteen randomised controlled trials have demonstrated that IPS achieves far superior outcomes across varying social, political, economic and welfare contexts. Studies have shown that 61% of people with serious mental health conditions can gain open competitive employment using Individual Placement and Support as compared with 23% for vocational rehabilitation. Randomised controlled trials in the United States have also shown that IPS participants have much better employment outcomes than people supported by more traditional approaches of providing vocational training and job preparation before undertaking the search for competitive employment.

[21] Researchers conclude that "compared to standard vocational rehabilitation services, IPS is, therefore, probably cost-saving and almost certainly more cost-effective as a way to help people with severe mental health difficulties into competitive employment."In a report for the UK Department of Work and Pensions, the authors calculated that for every

Internationally, the principles of the evidenced based supported employment approach have been strongly endorsed. Furthermore, the benefits of IPS have long been recognised in the Irish context. As far back as 2006, the Expert Group on AVFC reported that "a cost-effectiveness study of different employment models in England found that….individual placement and support (IPS) or 'place and train' projects were significantly more effective than other [traditional vocational] approaches in enabling people with mental health problems to find and keep open employment".[22]

Economic context

The IEMHS project took place in Ireland just as the country emerged from a significant and protracted economic recession, beginning in 2008, which has impacted on the delivery and results of the project. In June 2015 when the project began, the unemployment rate in Ireland was 9.4%, dropping to 6.3% in June 2017. Furthermore, these national figures mask regional variations and it has been acknowledged that the economic recovery was slower to take hold outside of Dublin, where each of the project's sites was located.

pound invested in the supported employment approach there was an expected saving of £1.51.The OECD has also identified that IPS produced better outcomes than alternative vocational services at a lower cost overall to the health and social care systems.

[22] Department of Health (2006), p. 38.

Site profiles

This section outlines the profile of each project site. Each section will include a description of the EmployAbility service and Employment Specialist, a description of the mental health service, and a general description of the type of clients supported by the mental health team.

There were two distinct types of mental health teams involved in the IEMHS project: Rehabilitation and Recovery Teams and generic Community Mental Health Teams (CMHTs). Rehabilitation and Recovery Teams provide specialized mental health care for people with severe and enduring mental health difficulties, whose needs cannot be adequately met by general adult services. The needs of people with severe and enduring mental health difficulties are often more complex and include treatment of long term difficulties and prevention of relapse, finding and maintaining accommodation, vocational and educational training, improvement of social skills and prevention of social exclusion. Generic Community Mental Health Teams, on the other hand, deal less with the type of complex needs catered for by the Rehabilitation and Recovery Teams. Community Mental Health Teams treat and support people in their own homes and communities as much as possible and rely on hospital care as little as possible.

Cavan/Monaghan

The Cavan/Monaghan EmployAbility service was established in 1999 and is based in the north east of the country. The catchment population of this service is approximately 138,000 people. The number of adults with a disability of working age within this catchment area is 15,187 (CSO, 2016). The number of adults with a disability of working age who are in employment in this area is 3,026. This means that of adults with a disability of working age within this catchment area, the labour market participation rate is approximately 20%. The labour market participation rate for the rest of the population in this area is 61%.

The Employment Specialist from this EmployAbility service was a qualified Occupational Therapist and had some limited experience as a job coach in the local area. The Employment Specialist took maternity leave and was replaced temporarily by another Employment Specialist of significant experience. This did have some impact on the fidelity of the service in that area, as the replacement Employment Specialist did not have the same level of access to client files.

The mental health service in Cavan/Monaghan involved in the IEMHS project was a Rehabilitation and Recovery team. The team provides care to those with severe and enduring mental health needs. The CMHT in this area is well established and has been in operation since as far back as 1999. During the IEMHS project there was the complete loss of an OT, which had a significant impact on the

provision of the service. A Consultant Psychiatrist was also replaced, which again, impacted on the service provision.

Castlebar

The Mayo EmployAbility service was established in 2001 and is based in the west of the country, in Castlebar. The local catchment population is approximately 130,000 people. The number of adults with a disability of working age within this catchment area is 16,666 (CSO, 2017). The number of adults with a disability of working age who are in employment in this area is 2,959. This means that of adults with a disability of working age within this catchment area, the labour market participation rate is approximately 18%. The labour market participation rate for the rest of the population in this area is 57.7%.

The Employment Specialist from this EmployAbility service had a background in Marketing, HR and was an accredited Counsellor, with experience working with vulnerable populations. The Employment Specialist was hired specifically for the IEMHS project and had no previous job coaching experience in the local area.

The Mayo mental health service involved in the project was a Rehabilitation and Recovery team, which was established as a functional MDT in 2008. The service provides support to those with severe and enduring mental health difficulties. The team has pointed out that they deal with a significant number of clients who have lived in institutions. Deinstitutionalisation is said to have been completed in 2006. During the IEMHS project there was a change in the original OT who had received IPS training. A replacement OT took up duty. This had an impact on the provision of the service.

Galway

The Galway EmployAbility service was established in 2000 and is based in the west of the country. The catchment population is approximately 80,000 people. The number of adults with a disability of working age within the catchment area of Galway City is 9,379 (CSO, 2017). The number of adults with a disability of working age who are in employment in this area is 2,444. This means that of adults with a disability of working age within this catchment area, the labour market participation rate is approximately 26%. The labour market participation rate for the rest of the population in this area is 61.3%.

The Employment Specialist from this site had some previous experience as a job coach in this local area and had the benefit of some local contacts. The Employment Specialist had a diverse professional background well suited to the role.

The Galway Roscommon mental health services involved in this project was a Rehabilitation and Recovery Service. The service provides support to those with severe and enduring mental health difficulties. The mental health team in this site has been in development since 2014. During the period of this project, the team involved was not populated by the disciplines required to deliver a high quality service. The team has been working with service users since May 2015; however, is not fully populated and the primary focus has been working with individuals living in staffed supported residences, often for many years, in order to address the objectives of national policy relating to supported accommodation.

During the IEMHS project there was a change in OT, which had a temporary impact on the provision of the service.

Bantry

The West Cork EmployAbility service was established in 2001. The catchment population for this service, in the west of the county, is approximately 100,000 people. While it is not possible to get accurate population and labour market statistics for West Cork, Cork county has a population of approximately 417,000. The number of adults with a disability of working age within the Cork county area is 46,796 (CSO, 2017). The number of adults with a disability of working age who are in employment in this area is 11,040. This means that of adults with a disability of working age within this catchment area, the labour market participation rate is approximately 24%. The labour market participation rate for the rest of the population in this area is 63%.

The Employment Specialist from this site has extensive experience as a job coach in this area and is deeply involved with local enterprise. This meant that the Employment Specialist could quickly draw on a range of established employer contacts in the area. The Employment Supervisor for this site left the post during the project and was subsequently replaced. This impacted temporarily on the Employment Specialist's supervisor, the overall fidelity of the site and the continuity of the service.

The Bantry mental health service involved in this project is a centre for mental health care and recovery and is the only generic Community Mental Health Team involved in the project. Generic Community Mental Health Teams manage fewer clients with the type of long-term, complex mental health difficulties that Rehabilitation and Recovery Teams support. The service also runs an Open Dialogue project which interfaced with this IPS pilot, though this interface has not been thoroughly

explored in this report. There was one major staff departures from in this site during the project which impacted on the service: a Consultant Psychiatrist.

Fidelity summary

This section will outline the fidelity evaluation process for the IPS model as well as the scores achieved by each site during the two assessments.

Fidelity evaluation process

The IPS model utilises a fidelity scale to measure the level of implementation of the model. The IPS Supported Employment Fidelity Scale defines the critical ingredients of IPS in order to differentiate between programmes that can legitimately claim to be delivering IPS and those that cannot. As demonstrated through research, high-fidelity programmes are expected to have greater effectiveness than low-fidelity programmes.[23] Programmes that have fidelity to the scale are said to be providing 'evidence-based supported employment'.

The fidelity scale looks at 25 areas of the IPS service being provided. Sites are graded based on their fulfilment of criteria under each of these sections. All key stakeholders involved in the delivery of the IPS service are interviewed, including the Employment Specialist, at least three members of the MDT, at least four IPS participants and, where appropriate, the participants' family members. Each section requires evidence (i.e. documentation) and corroboration between stakeholders. Once evidence has been collected and interviews are corroborated, a score for each section is given. When a total score is calculated, each site is then graded based on the IPS scoring scale below.

Table 7: IPS scoring scale

IPS scoring scale	
110-120	Exemplary Fidelity
95-109	Good Fidelity
69-94	Fair Fidelity
<68	Not IPS

MHR conducted the fidelity evaluations across all four sites, having received specialised fidelity evaluation training from external IPS experts, IMROC. Each evaluation was carried out by two trained MHR staff members. All interviews with MDT staff, Employment Specialists and participants were recorded, with permission, for the purposes of accuracy. The evaluators both scored each site independently and negotiated scoring differences where they arose, with external support. A draft write-up of each fidelity report was reviewed internally before being sent out to IPS sites. Each IPS

[23] Dartmouth IPS Supported Employment Center. Chapter 1: Introduction to IPS Supported Employment Fidelity Accessed March 2017. Available from: http://www.dartmouth.edu/~ips/page19/page49/page50/files/semanual. text.pdf

site team was given the opportunity to give feedback on the draft scoring, and where appropriate, provide evidence to contest any errors in the report. Once a final report was agreed between sites and MHR, it was reviewed externally by IMROC and the final reports were circulated to sites.

First phase of fidelity evaluation

The first fidelity evaluations were carried out in each project site between March and April 2016. These evaluations were intended as a baseline to inform sites about areas requiring focus for their implementation. The results of these evaluations are displayed in the table below. The scores indicate that three out of four of the sites were providing at least a 'fair' level of evidence-based supported employment. While demonstrating some aspects of the model, the Castlebar site did not achieve sufficient points in their 2016 evaluation to meet the required standard for IPS. All of the sites at this point needed improvement to reach a good level of fidelity.

During the first phase of fidelity evaluations, all sites performed well in some common areas. Caseload sizes in all sites were less than twenty participants per Employment Specialist, which is consistent with high fidelity scoring. Integration of Employment Specialists into mental health teams was also working well in each site, with many Employment Specialists settling into their teams well. Sites also scored well in the area of disclosure, by effectively tracking their clients' preference for disclosing their mental health difficulty to employers.

Many sites needed to improve in the area of Executive Team Support, by improving the engagement of mental health service management with the IEMHS project. All sites needed to improve their documentation in the areas of Job Development and Frequent Employer Contact, so that work done on these sections was clear to the evaluators. All sites needed to increase the number of participant meetings held in community settings, which is a core part of IPS.

Fidelity evaluation scores per site

Sites	Cav/Mon	Castlebar	Galway	Bantry
Score	84 (Fair)	67 (Not IPS)	87 (Fair)	93 (Fair)

Second phase of fidelity evaluation

The second round of fidelity evaluations took place in March and April 2017. The results of these evaluations are displayed in the table below**.** The scores for the second round of evaluations demonstrate a clear improvement in fidelity across all sites. In particular, all sites had improved the number of participant meetings in the community. Documentation across all areas had improved

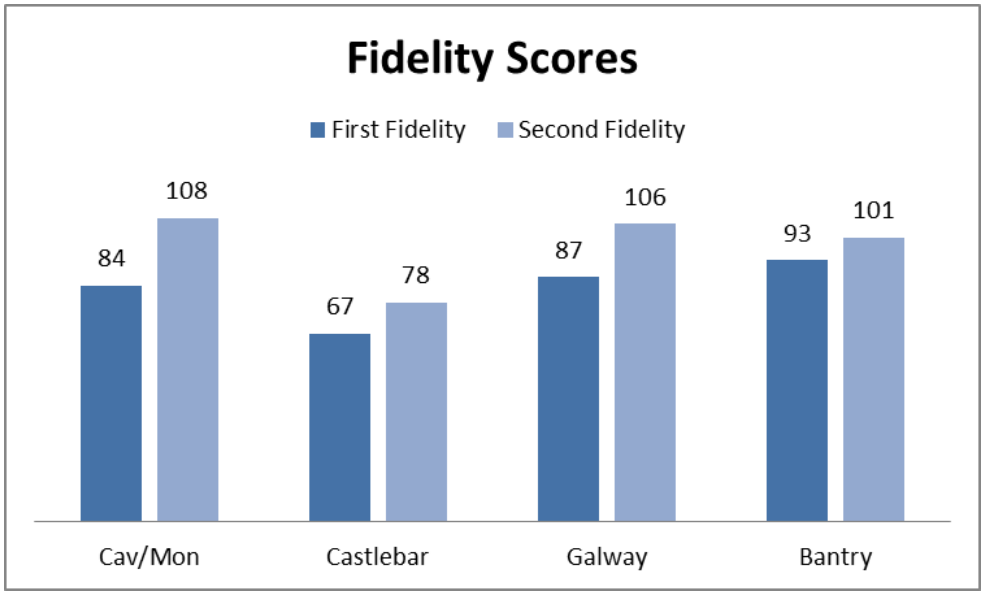
significantly and this benefited site scores. Integration of Employment Specialists had improved and was working extremely well.

Many sites still fell slightly short of the highest level of fidelity due to insufficient executive team support, and inconsistent supervision of Employment Specialists. Three of the four sites were providing at least a 'good' level of fidelity at the time of the evaluations while Castlebar was providing a 'fair' level of fidelity.

Fidelity evaluation scores per site

Sites	Cav/Mon	Castlebar	Galway	Bantry
Score	108 (Good)	78 (Fair)	106 (Good)	101 (Good)

A comparison of each fidelity evaluation score per site can be seen in the graph below.



Fidelity action plans

Following receipt of their fidelity evaluation score and project-wide discussion at a Learning Set, each site was asked to develop a Fidelity Action Plan. A Fidelity Action Plan is a document, developed by an IPS team, which takes into account the feedback from a fidelity evaluation report and sets out a plan for improved fidelity to the IPS model in the future. Fidelity Action Plans were received from all four sites following the receipt of their fidelity evaluation reports. A sample of some Fidelity Action Plan content can be found in the appendix.

Additional support

In addition to developing a Fidelity Action Plan, the Castlebar site was offered additional support to improve their fidelity score, given that the site did not initially achieve a minimum IPS standard. Conference calls were organised with external IPS experts to work through specific client challenges that arose in Castlebar.

Demographic profile

Total number of participants

The IEMHS project set out to work with a minimum of 20 participants in each project site. In total, 95 participants took part in the project. There were 20 participants exited from the project. Participants are exited from the project if they no longer express an interest in searching for paid competitive employment. Participants are exited only after reasonable outreach efforts are made by the Employment Specialist and the MDT. There have been 10 participants temporarily 'placed on hold' during the project. Participants are placed on hold during the project for a variety of reasons, although most commonly participants are placed on hold due to difficulties that arise in relation to their mental health.

By the end of the project there were 65 active participants involved. The distribution of participants in each project site can be seen in the table below.

Distribution of participants.

	Cav/Mon	Castlebar	Galway	Bantry
All Participants	22	21	23	29
Active Participants at end of project	18	14	13	20

Age and gender profile

The average age of participants in the IEMHS project was 40. The majority of participants, 57 people, identified themselves as being male. The remaining 38 participants identified as being female. A full breakdown of age and gender per site can be found in the table below.

Age & gender profile across sites

	Cav/Mon	Castlebar	Galway	Bantry
Average age	40	45	37	40
Male	16	12	18	11
Female	6	9	5	18

Social welfare profile

The majority of participants involved in the IEMHS project, 75%, were in receipt of Disability Allowance; 6% of project participants were in receipt of Illness Benefit; 6% of participants in the project receive no social welfare payment. The remaining 14% of participants are in receipt of miscellaneous payments including Invalidity Pension, Widows Pension and Jobseeker's Allowance. In order to obtain high fidelity to the IPS model, each project site must ensure that participants receive comprehensive and independent counselling regarding their benefits and how these can and will change throughout the course of their involvement with the IEMHS project.

Payment	**DA**	**IB**	**None**	**JSA**	**IP**	**OPFA**	**WP**	**TP**	**Unknown**
No.	70	6	6	3	2	1	1	1	5
%	75%	6%	6%	3%	2%	1%	1%	1%	5%

Education profile

Participants had relatively low education levels compared to the general working-age population: 73% of all participants indicated they had a 2nd level education, with most having obtained a junior certificate or equivalent QQI qualification up to level 5; 11% of all participants had a third level qualification; 7% of all participants had primary level education only; and 9% reported having no formal education whatsoever.

Level	**1st level**	**2nd Level**	**3rd Level**	**None**	**Unknown**
No.	7	69	10	8	1
%	7%	73%	11%	9%	1%

Employment history

Previous work experience has been demonstrated as a predictive factor of successful supported employment outcomes.[24] In the IEMHS pilot, 46% of all 95 participants have held some form of employment within the last 9 years. 13% of all participants have had no employment for over 10

24 Viering, S., Jaeger, M. & Kawohl, W. (2015) 'Which Factors Influence the Success of Supported Employment?', Psychiatrische Praxis 42(6):299-308.

years and 13% of all participants have had no employment for over 20 years. 26% of all participants have never been in mainstream employment before.

Employment history varies from one site to another and to some extent reflects the nature of the mental health services in that area. The MDT in Bantry, for example, is a generic Community Mental Health Team and therefore deals less with the type of long-term, complex mental health difficulties that the Rehabilitation and Recovery teams deal with in the other three sites. 66% of all participants involved in the IEMHS project in Bantry have been in employment in the last 9 years and 7% have never worked before. In contrast, in Cavan/Monaghan, a Rehabilitation and Recovery team site, 41% of all participants have been in employment within the last 9 years, 18% have been in employment between 10-19 years ago, and 32% have never been in employment before. The full profile of employment history per site can be seen in the table below.

Years since last employment

Last employment	Cav/Mon	Castlebar	Galway	Bantry
0-9 years	9 (41%)	7 (33%)	8 (35%)	19 (66%)
10-19 years	4 (18%)	4 (19%)	5 (22%)	2 (7%)
Over 20 years	1 (5%)	5 (24%)	4 (17%)	2 (7%)
Never	7 (32%)	5 (24%)	6 (26%)	2 (7%)
Unknown	1 (5%)			4 (14%)

Co-occurring individual barriers

From the perspective of the Employment Specialists, many individuals participating in the project also experienced a range of co-occurring individual barriers. The most common barrier reported by Employment Specialists was cognitive impairment in participants. Cognitive impairment might include noticeable difficulties with cogitative abilities, such as perception, memory, motivation, thinking, reasoning and awareness.[25] Other participants were reported to have specific learning difficulties, including dyslexia, dyspraxia and dyscalculia. Employment Specialists reported that a number of participants had difficulties with their physical health, such as diabetes, skin conditions and cancer. Finally, a number of participants were reported to have co-occurring disabilities. These

25 Green, M.F. (1993) What are the Functional Consequences of Neurocognitive Deficits in Schizophrenia? American Journal of Psychiatry, 153, 321-330

were reported as sight loss, hearing loss and physical disabilities. At least one site reported time keeping difficulties among its participants as a barrier.

Outcomes

Job placements

In research on IPS, typically a job placement under the model counts as any paid competitive position within mainstream employment. The international evidence for IPS shows that about half of IPS clients will not obtain a competitive job through the programme. Of the 95 participants that have been involved in the IEMHS project, 33 (36%) have had at least one job placement. Of these 29 participants, 10 (10%) have had more than one job placement.

Job placements

	Cav/Mon	Castlebar	Galway	Bantry
No. of job placements	10	3	4	16
Percentage of successful job placements	45%	14%	17%	55%

60% of the 65 active participants on the IEMHS were job searching at the end of the project. The table below demonstrates the number of active participants involved at the end of the project, alongside the number of participants job searching at the end of the project. It should be noted that a number of the participants that were job searching at the end of the project, had previously had a job placement within the IPS project.

Currently job searching

	Cav/Mon	Castlebar	Galway	Bantry
Active participants	18	13	19	20
Active participants job searching	11	13	17	10
In Supported Employment	7	0	2	10

Employment outcomes

The average number of hours worked per week by successful applicants was approximately 21 hours.

Hours per week

Hours per week	No. of participants
1-10 hours	7
11-33	17
34+	5
Unknown	4

The average weekly wage for successful participants was approximately €230. 21% of successful participants had downward adjustments to their social welfare payments and 18% relinquished their social welfare payments entirely. 20% of successful participants utilised the Wage Subsidy Scheme (WSS).

Weekly wage

Wage in €	No. of participants
€10-€150	12
€150-€250	9
€250-€350	2
€350-€500	6
Unknown	4

Successful participants worked across a very broad range of sectors. This is typical of IPS, as participants search for jobs in accordance with their own preference. Some examples of the types of positions acquired include:

- Fitter (Building)
- Kitchen Assistant
- Event Organiser
- Office Cleaner
- Telesales
- Retail Assistant
- Accountant
- Crane Operator
- Laundry Assistant
- HGV Driver
- Hotel Receptionist
- Web Designer

Of the 29 participants who achieved a work placement, 20 (68%) were still in employment by the end of the project. As the majority of participants who achieved a work placement were still employed by the end of the project, it is not possible to say, on average, how long each individual remained in

their position. However, as of the end of the project, on average, each successful applicant had been in their position for over 55 weeks.

Other outcomes

18 out of 95 (19%) participants went on to further training as a result of their involvement with the IPS programme. Many participants took on Safe Pass training, which is a certificate aimed at construction workers and is a prerequisite for working on building sites in Ireland. Other participants moved on to full-time education, most commonly with the National Learning Network. The next most common training was IT training, particularly the European Computer Driving License (ECDL) course.

5 out of 95 (5%) participants moved from supported accommodation to independent living during their participation in the IEMHS project. Employments Specialists reported that many participants showed significant improvement in their levels of independence and achieved very positive personal development while involved in the project. An Employment Specialist wrote of one participant:

> "Starting NLN. Improved independence, reduced anxiety, moved house, needs less supported living, able to walk on own, able to get bus on own, improvement in personal hygiene. Improved organisation skill - uses diary. Now able to get to [Local area] and [Other local area] on own. Gaining life skills."

Another participant had outcomes described as,

> "Improved independence, reduced anxiety, able to go out on own (not assisted), get bus, improved social contact and skills. Joined football group and other outings, improved independence."

Participant case study

As there is a great deal of variance between each IPS participant and the types of jobs they acquire, an example has been provided below for illustrative purposes.

M.C. has a mental health difficulty and lives in supported accommodation. During an appointment with his OT, he expressed an interest in finding a job. The OT referred him to the Employment Specialist on the IPS project. M.C. had never worked before and has a junior certificate qualification.

After an initial assessment of his skills and interests, the Employment Specialist helps M.C. draw up a CV. M.C. is interested in being a manager of a restaurant. As M.C. does not currently have the qualifications or experience for this position, the Employment Specialist, along with the OT, coach M.C. to understand that he must start at a lower level than manager in order to gain experience. Within 3 weeks of his referral, M.C. begins applying for jobs in local restaurants and cafés. During this period, the Employment Specialist works on interview skills with M.C. and they discuss the types of tasks that would be involved in day to day restaurant work.

After 1 month of applying for jobs, the Employment Specialist approaches a restaurant with M.C.'s CV. The Employment Specialist pitches M.C.'s CV for a vacancy they have for a kitchen porter. The employer is not told that M.C. has a mental health difficulty, in accordance with his wishes, but the employer is told that M.C. will receive some support on the job. M.C. receives an invitation to interview. The Employment Specialist begins to focus on job interviewing skills with M.C. M.C.'s mental health team is made aware that M.C. will have a job interview shortly.

On the week of the interview, M.C. becomes extremely anxious. The Employment Specialist, who is going through some final preparations with M.C. calls his OT. The OT comes to meet with M.C. at his home to discuss his feelings about the interview. After meeting with his OT, M.C. decides he will be able to attempt the job interview. M.C. does the interview and is offered a job as a kitchen porter, for 15 hours per week, at minimum wage.

The Employment Specialist discusses with the employer some of the tasks M.C. will be expected to do. The Employment Specialist prepares M.C. for these tasks before his start date. M.C. has some memory difficulties and the employment specialist works with him to draw up a checklist of tasks when he begins his day of work. The Employment Specialist discusses personal hygiene with M.C. and the types of clothes he needs to wear on the day. The Employment Specialist does some role play with M.C. so that he is comfortable with the types of interactions he can expect.

On his first day, the Employment Specialist meets M.C. before work. M.C. is reassured that all the tasks have been practised and that he is dressed and presented appropriately for his shift. The Employment Specialist calls M.C. on his break and after his shift to make sure he is okay. Throughout his first month of work, the Employment Specialist along with the mental health team, offers M.C. high levels of support. When M.C. becomes anxious or displays signs of becoming unwell, the Employment Specialists feeds this back into the mental health team and appropriate interventions are deployed. The employer is happy with M.C.'s work but asks that he speed up and better prioritise the tasks he is given. The Employment Specialist drafts a shift planner for M.C. to help him prioritise the most important tasks based on the employer's feedback.

After 3 months of part time work, M.C. encounters some difficulties with his mental health and becomes unwell: He must take some time off work to recover. The Employment Specialist briefs the employer in an appropriate way and the employer is happy to hold M.C.'s position for a number of weeks. After 3 weeks, M.C. becomes well enough again to be able to go back to work. He resumes with high support from his mental health team and the Employment Specialist to make sure he is doing okay.

M.C. is still involved in the project and continues to work as a kitchen porter with some support.

R.B. has a mental health difficulty and lives in supported accommodation. During an appointment with his OT, he expressed an interest in finding a job. The OT referred him to the Employment Specialist on the IPS project. R.B. had never worked before and has no formal qualifications.

After an initial assessment of his skills and interests, the Employment Specialist helps R.B. draw up a CV. R.B. is interested in working as a mechanic in a garage. R.B. does not have the qualifications or experience for this position.

Within 4 weeks of his referral, R.B. begins applying for jobs in local garages. In particular, the Employment Specialists helps R.B. look for non-skilled garage jobs, such as cleaning staff or administration staff. During this period, the Employment Specialist works on interview skills with R.B. and they discuss the types of tasks that would be involved in day to day garage work.

After a number of weeks searching, the Employment Specialists approaches a car garage and explains that she has a client interested in working in the garage as an assistant. While the garage has no current vacancies advertised, the garage manager agrees to give R.B. a trial. He explains that R.B. would be required to clean up after the mechanics, replace tools and perform other house-keeping duties. The Employment Specialist explains to the garage manager that her client will need some reasonable accommodation to carry out these tasks. The Employment Specialist explains, without going into detail, that R.B. has a disability and requires a little patience, but will be capable of performing the duty.

The Employment Specialist approaches R.B. with this offer and R.B. accepts the trial. The Employment Specialist begins preparing R.B. for the first week of the job trial. The Employment Specialist explains the need to be punctual and well presented for the job and develops a checklist with R.B. for morning routines before a shift. The Employment Specialist helps R.B. develop a plan to get to and from work by bus. The Employment Specialist practises with R.B. some tasks that will be expected.

On the first day of the job trial, the Employment Specialist accompanies R.B. to the garage and spends a number of hours helping R.B. with tasks. This makes R.B. comfortable and helps R.B. to settle in. The Employment Specialist then leaves R.B. to complete the shift. When the shift is complete, the Employment Specialist meets with R.B. to discuss how things went. The Employment Specialist also calls the garage manager to get some feedback on R.B.'s performance. Together, R.B. and the Employment Specialist run through some things that could be improved upon for the following shift.

R.B. successfully completes the work trial and the garage manager offers R.B. a position part time. R.B. accepts.

After a number of weeks R.B. tells the Employment Specialist that he is having difficulty getting to work as local busses are unreliable. The Employment Specialist helps R.B. pick out and purchase a bicycle which R.B. uses to get to work.

Costs

This section will outline the costs of the IEMHS project, looking both at the cumulative costs of Employment Specialists and the direct costs.

Employability staffing costs

The core costs for Employments Specialists for the periods June 2015 to May 2017 are listed below. The amounts listed are the total costs across the four sites.

Employment Specialist costs (salary and PRSI)

Period	Amount
June – December 2015	€52,891.75
January - December 2016	€104,885.57
January – May 2017	€54,992.09
Total	€212,769.41

Project expenses

Description	€
Employment Specialist travel	13,557
Employment Specialist phone	1,832
Ongoing direct costs	1,521
Subtotal ongoing direct costs	16,910
Equipment	2,599
Imroc consultancy	12,417
Learning set costs	4,667
Subtotal training costs	17,084
Project Management Staff time 2015	17,919
Project Management. Staff time 2016	8,448
Sundry	597
Subtotal Project Management	26,964

Total other project costs	63,557

Cost benefit analysis

A full independent cost benefit analysis of this pilot project has been completed by the UK Centre for Mental Health. This report can be found in full in the Appendix. A summary extract of their analysis can be found below.

Summary of cost benefit analysis

There were significant differences between the four IEMHS project sites, which meant that in reality, there were four very small IPS services, rather than one project/service with four areas working in close parallel. In our experience, it is very difficult for a single IPS worker (especially with external supervision) to achieve the hoped for numbers of referrals and sustained job outcomes. However, the project has demonstrated that IPS can be implemented to good fidelity within 12-14 months and that job outcomes approaching expected levels can be achieved. If the services had been staffed with 2-3 Employment Specialists to support one another, they may have been able to get closer to achieving job outcomes of around 35-40%.

The cost benefits of the IEMHS service are promising. Value for money would improve if a higher number of service users claiming benefits could be helped into work of sufficient hours and pay to substantially reduce benefit claims.

As a proof of concept this experiment has been a success. Actual cost savings are difficult to calculate without an equivalent counterfactual (control site) but it is very reasonable to believe that few of the service users who had been out of work for over 9 years (or even at least 4 years) would have achieved an employment outcome without the IPS service supporting them.

As a next step, we recommend that at least two IPS sites and a control site work with 200 service users each, over 2 years, and that the job outcomes and estimated benefit savings are compared, along with follow-up data on the service users from this project, to establish how many appear to have reduced their use of mental health services compared with use of services in the previous 5 years.

Discussion

This section will outline the various challenges the IEMHS project encountered and how these were navigated and overcome, as well as a number of perceived benefits to the IEMHS approach.

Operational challenges

Client information sharing

IPS requires that Employment Specialists be able to participate in multidisciplinary team meetings and that they have a consolidated case file so that employment support information is located within the clinical case file. In the Irish context, with the requirements of the Data Protection Act and other confidentiality agreements, this meant that a data sharing agreement had to be reached between the two services in each site. A significant early achievement for the project was the development of an inter-agency data sharing protocol for each project site. This involved data sharing protocols being reached between the HSE and the local EmployAbility services. The data sharing protocols allowed Employment Specialists to have access to MDT meetings and to write in clinical files. Each Employment Specialist received either formal or informal supervision within the MDT on how to write into clinical files. Agreement on data sharing was key to being able to provide the integrated, seamless employment support for mental health service users by both EmployAbility and mental health services.

Co-location

As the IEMHS project brings together two different services, and the IPS model requires the Employment Specialist to be located within the MDT, there was a significant decision and implementation process to allow the Employment Specialists to be situated on a regular basis within the MDT's premises. This was implemented differently in each of the sites depending on their circumstances. In the Galway site, for example, as the service was new, the MDT had not yet moved into new premises. This meant that the Employment Specialist was based initially in the EmployAbility service with significant time spent out in the community meeting with participants. Once the MDT acquired new premises, the Employment Specialist shared an office space with the OT manager and also retained an office space in the EmployAbility service. Again, co-location would not have been possible without the presence of the inter-agency data sharing protocol. The achievement of co-location enabled the type of ongoing, informal communication between Employment Specialists and MDT staff members that is vital to the successful implementation of evidence-based supported employment. A number of sites reported that co-location worked very well. For example the Castlebar Employment Specialist reported that she was made to feel very much part of the MDT by fellow team members and other Mayo Mental Health Services Staff.

Attitude change towards non-exclusion

The IPS model emphasises the importance of zero exclusion of any participant interested in searching for employment. Regardless of a participant's skillset, job readiness or mental health difficulties, if an interest in competitive employment is expressed, the individual is eligible for the IPS programme. This is different to the way both the mental health services and the EmployAbility services operate when it comes to employment, in that their services are based on specific eligibility criteria or informal exclusion. For EmployAbility services, individuals who are not 'job ready', meaning not having the required skills, education or experience, are excluded from the service. For mental health teams, a less formal arrangement may exist where people may be discouraged from seeking work if they are not seen as being ready or well enough to do so. Moving to zero exclusion therefore proved to be a significant challenge for both services, who had limited or no experience of this way of working.

When zero exclusion did not work effectively on the ground, it often did not manifest in the form of explicit exclusion from the IPS service. Instead, sometimes services focused too much on job readiness, sometimes putting IEMHS participants forward for volunteering positions, rather than paid employment, or having participants' job search slowed down in favour of upskilling and education. To help both EmployAbility services and mental health teams be more effective with the non-exclusion requirement of IPS, specific training was provided at Learning Sets and external experts were brought in to help teams develop strategies for cases they found particularly difficult. While the non-exclusion requirement of IPS improved across all sites over the course of the project, some IEMHS participants did ultimately opt for volunteering positions rather than competitive employment.

Challenges of cross-departmental working

An initial challenge of the IEMHS project involved creating the higher level governance structure to oversee the project across two government departments (the Department of Health and the Department of Employment Affairs and Social Protection) and the HSE. No real precedent or existing framework for joint governance of a service such as this had been in place before IEMHS, as far as Mental Health Reform was aware. The IEMHS steering committee was established as the forum for strategy and collaboration for the IEMHS project.

While each department and the HSE worked extensively to support the IEMHS project in their own areas throughout the project, the coordination and strategy of this work came from the IEMHS steering committee. The extent of collaboration and flexibility offered by all project stakeholders

from an early stage and throughout the IEMHS project has been key to being able to deliver on the project aim.

An example of this is the work needed to get Employment Specialists into post and to set up the necessary payment and claim systems needed for the project to operate. In order to get Employment Specialists into post, DEASP worked closely with local EmployAbility services to identify candidates or, where appropriate, redeploy existing EmployAbility staff and back fill subsequent vacancies. This was a lengthy task and required coordination across all stakeholders in order to meet tight project deadlines.

Thereafter, a claims system was needed so that each site could claim ongoing project expenses, salaries and any initial start-up costs. The project required a dual claims procedure, with salary claims being processed by the Department of Employment Affairs and Social Protection and other project expense claims being processed by MHR. Once this was established, appropriate documentation and procedures were developed and agreed among all stakeholders. However, there were significant 'teething' problems in establishing the claims system, particularly for salary claims. Having a separate, new claim system for this project instead of using the normal EmployAbility service claim procedures, led to significant delays in payment of salaries for some Employment Specialists, particularly at the start of the project. It would be important in any future project to plan early for financial disbursement procedures.

Gaps in staffing

Throughout the project, a number of gaps in staffing occurred, which created difficulties for the IEMHS project. In Cavan/Monaghan, for example, the Employment Specialist took maternity leave which led to lower numbers of clients being supported during that period. Another Employment Specialist was drafted in to cover this maternity leave; however, this new Employment Specialist was not covered by the same confidentiality agreement as the original Employment Specialist, which resulted in a much lower level of fidelity to the IPS model. Similarly, the first OT involved in the IEMHS project in Galway went on maternity leave which resulted in a gap in staffing that had an impact on the level of fidelity and service in that site. Another difficulty arose in Cork when the original EmployAbility Coordinator left the post. There was a gap of approximately one month where no supervision or coordination could be provided for the Employment Specialist there, which had an impact on the site's fidelity and level of service. There was also a change in Consultant Psychiatrist in this site, and this had some impact on the general continuity of the project. In the Castlebar site, an OT went on Maternity Leave and did not return to the post within the Rehab and Recovery Team. The new OT appointed to the MDT did not have specific IPS training.

Fidelity challenges

Rapid job-searching

The completion of the first round of fidelity evaluations brought about a number of challenges for the project, both at management level and on the ground. The initial fidelity evaluations gave the first real indication of the types of services that were being provided in each site. Across all sites, some core IPS principles were not being implemented as effectively as possible and therefore it was important that this be addressed. In particular, more emphasis needed to be placed on the importance of rapid job searching for participants within the first four weeks of their intake. Similarly, focus needed to be shifted away from the criterion of job readiness, which includes the reliance on volunteering positions and training courses to prepare a participant for work, something that is out of line with IPS. In order to address fidelity- related difficulties, substantial work was undertaken to develop strategies to improve these particular issues. Conference calls and learning sets were arranged to look specifically at these difficulties and external experts were brought in to offer advice to Employment Specialists and other MDT members. On foot of this support, all of the sites improved the rapidity with which their clients were beginning job searching.

Documentation

Developing appropriate documentation for the project proved to be difficult. Employment Specialists and their Supervisors want to provide a client-focused service and spend as little time on perceived non-value added activities as possible. On the other hand, due to IEMHS being a pilot project, there was a necessary burden of data collection and measurement. Optimising these two conflicting demands was difficult. To compromise, many of the documents were completed online and reporting deadlines were spread out throughout the year, so as to minimise impact on the Employment Specialists. Employment Specialists and their Supervisors were consulted on data should be collected and how this should be done, and through this process, key indicators were established that all parties were satisfied with.

Continuity of documentation

Continuity of documentation for the purposes of measuring outcomes has been a difficulty as a number of staff members, particularly Occupational Therapists (OTs), moved on from their roles during the project. OTs are central to the IPS model because they play a key liaison role with the Employment Specialists, and during the pilot were particularly important in taking some of the pilot measurements. It had been intended that both the Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS) and the Manchester Short Assessment of Quality of Life (Mansa) would be used to measure a baseline and end of project assessment of each IEMHS participant, to develop an insight

into any changes that may have happened in participants' experience and wellbeing over the course of the project. However, as OTs moved on and new OTs took up post, the practice of completing a baseline assessment with participants was not always kept up. Without a baseline assessment, a follow up assessment is of little or no value and therefore, a number of clients and sites do not have the full complement of data that was envisaged.

Client challenges

Managing client expectations

Employment Specialists and MDTs encountered some ambitious expectations from participants that required team support. In some instances, participants had unrealistic expectations of the types of jobs they could apply for. For example, a participant may have wanted to search for jobs in a managerial role without having the required qualifications or experience. In order to give the participant the best chance of a successful outcome, Employment Specialists and MDTs worked together to coach participants to understand the need to work incrementally towards higher level positions. In some cases, certain qualifications and certificates were recommended to participants in order to build on their existing education and experience and prepare them for their preferred role.

Inappropriate social behaviour

Other participants demonstrated difficult or inappropriate social behaviour such as aggressiveness, sexualised behaviour or personal hygiene issues. In these circumstances, more input was necessary from the Employment Specialists and MDTs once the participant was in employment, in order to keep the participant in employment. In this cases where participants had a tendency to become aggressive or demonstrated inappropriate sexual behaviour, Employment Specialists often looked for work that didn't have a significant social aspect. This might include something of an outdoor nature, such as grounds keeping. Employment Specialists and the MDTs worked incrementally with these participants on each aspect of their behaviour that might present a difficulty when in a work environment. For example, an Employment Specialist might remind a participant before a shift that it is important to shower before work. By working in this way, participants built skills and understanding about how to behave in the work environment. If a participant became hostile during work, this would be reported to the MDT or Employment Specialists so they could work with the client to prevent it from happening again.

Benefits

This section will highlight some of the benefits of the IEMHS project.

Participant benefits

During interviews for the IPS fidelity evaluations, IEMHS participants, Employment Specialists and MDT members all had the opportunity to give their feedback about the IEMHS project and their experience of IPS. This feedback is reflected in the following discussion of the benefits of the IEMHS project.

The benefits of IEMHS can be considered in terms of outcomes for clients, positive changes experienced by staff of EmployAbility and/or mental health services, benefits to the structural framework underpinning agency action on social inclusion of people with mental health disabilities, and benefits to Irish society as a whole.

Benefits to clients

Employment outcomes

As the primary aim of IPS is to enable individuals with severe mental health difficulties to obtain competitive employment, employment outcomes are an essential criterion of evaluation of the IEMHS project. As a result of participating in the IEMHS project, 31% of participants, or 33 out of 95, achieved at least one competitive job placement. The employment outcomes varied in each site, and while there are various reasons for this, one key variable is the relative distance of participants from the labour force. In the site where clients had, on average, more recent work experience (West Cork), the percentage who achieved at least one competitive job placement was 55% of all participants in that site. In Cavan/Monaghan, a site where participants had relatively little recent work experience, 45% achieved a competitive job placement. The sites that achieved fewer job placements, Galway at 17% and Castlebar at 14%, had participant caseloads that were relatively further from the labour force than the other sites. For example, when we look at the number of people who had previous work experience within the last 9 years, Bantry had 19 participants (66% of their caseload) and Cavan/Monaghan had 9 (41% of their caseload) whereas Castlebar and Galway had 7 (33% of caseload) and 8 (35% of caseload) respectively.

Many of these participants stated that they had very low expectations of ever gaining mainstream competitive employment. Many also had extremely limited opportunities to gain employment through the current supported employment programme due to its 'job ready' eligibility criterion. Given that people are more likely to obtain employment once they have been in previous employment, it is also reasonable to expect that all of the job-placed participants are more likely to have job placements in the future than would have been the case if they had not participated in the project. Thus, the long-term positive impact of the IEMHS project, and IPS more generally, on participants can be said to be compounding in nature – increasing job placements over time and

reducing the likelihood in the long term that these participants will remain wholly reliant on social welfare.

In terms of the quality of support provided, when interviewed during the fidelity evaluations, participants said that they felt very well supported in their search for employment or that they were well supported when they were in work.

> "[Employment Specialist] is great, she's helping me look for a job. I'm really into sports so we have been handing CVs into the local gym"

From the perspective of achieving competitive employment opportunities for IEMHS participants, the project has successfully done this for over one third of participants.

Financial benefit

Many of the IEMHS participants received financial benefit as a result of their participation in the project. The average weekly wage for participants that gained employment was approximately €230, and in many cases this was on top of a base social welfare payment. 21% of participants in employment had downward adjustments to their social welfare payments during the project and 18% relinquished their social welfare payments entirely. It is also worth noting that this reduction in benefit claimants was achieved before any of the 'Make Work Pay' report's recommendations had been put into effect (e.g. retention of free travel).

Participants interviewed during the project agreed that financial benefit was an important part of their motivation to work. Participants said that the money they earned through the IPS gave them extra freedom and independence.

> "I get an extra €70 on top of my DA which is great. I'm able to get out that bit more. I've bought a few new clothes which I haven't done in a long time."

Unanticipated participant outcomes

Employment Specialists noted significant unanticipated secondary benefits for clients from their involvement in the IEMHS project. Employment Specialists recorded that many clients gained more independence either as a result of job searching, a job trial or a job placement. 5 out of 95 (5%) participants moved from supported accommodation to independent living during their participation in the IEMHS project.

Employment Specialists also noted other personal development milestones that clients achieved during the project. Some clients were able to travel on public transport alone for the first time. Other clients were described as being more comfortable socially and capable of engaging more readily with

their peers and community. Employment Specialists and MDT members also noted that many clients had improvements in their personal hygiene and appearance, as a result of preparing to return to work.

Both MDT members and Employment Specialists expressed that a number of clients had marked improvements in their mental health during their participation in the project. Most commonly, it was reported that clients felt less anxious, needed less mental health support and needed less treatment in hospital. The following notes were recorded by Employment Specialists in their outcome reports on clients,

> "Starting NLN. Improved independence, reduced anxiety, able to go out on own (not assisted), get bus, improved social contact and skills. Joined football group and other outings, improved independence"
>
> "Further independence and no admissions for last 6 months"
>
> "Further independence and no admission, improved mental health"
>
> "Starting NLN. Improved independence, moved house needs to less supported living, able to walk on own, able to get bus on own, improvement in personal hygiene. Improved organisation skill, uses diary."

Benefits to mental health services

Throughout the IEMHS project, MDT members had the opportunity to give feedback during fidelity evaluation interviews and at learning sets. MDT members noted that their team's involvement in the IEMHS project had been beneficial in a number of ways.

Opening up employment as a part of recovery/care planning – a more hopeful mental health service

MDT members expressed that as a result of the introduction of an Employment Specialist into the MDT, employment featured as a constant topic of conversation for each client. MDT members expressed that instead of employment being more the role of the Occupational Therapists, employment actually featured as much more of a multidisciplinary conversation. It was felt that conversations around employment happened much earlier on in a client's recovery plan and that this was very positive. MDT members also noted that there was a very significant demand for the IPS service and that a full time Employment Specialist would have no problem with receiving enough referrals. This increase in discussions about employment within the context of care planning indicates the type of hopeful attitude that is a core part of a recovery-orientated mental health service, as defined by Mental Health Reform, the Mental Health Commission and international experts. People who use mental health services have said that experiencing a hopeful attitude from those around them is an aid to their recovery. Thus, the IEMHS project has demonstrated that

implementing IPS through integrating Employment Specialists into MDTs can contribute to achieving the hopeful attitude required for a recovery-orientated mental health service.

Multidisciplinary benefits

The benefits to MDTs went beyond the value of having an extra, specialist resource as a member of the team. They included better team-working and more creative thinking about clients' recovery/care planning.

Many MDT members mentioned that IPS helped them think in a more multidisciplinary manner. It was said that the topic of employment was a good 'leveller' in conversations around clients' recovery in that no mental health professional had exclusive authority over the issue, and that having an Employment Specialist also helped in this way.

MDT members expressed that the zero exclusion requirement challenged them to think more openly and creatively about clients' recovery. Finally, MDT members said that because of the stronger links between EmployAbility services and the MDT, they gained a better understanding of the types of local employment opportunities for clients, and that this helped them to understand the local context better.

Again, the feedback from mental health team members suggests that implementing IPS through having a dedicated Employment Specialist within the team can positively contribute to the overall recovery-orientated working of the team, not just because the Employment Specialist engages individual clients in job searching, but also because of the way that employment becomes an intrinsic part of recovery/care planning and initiates greater creative thinking about social inclusion on the part of MDT members.

Benefits to EmployAbility services

Better communication with mental health services leading to better job retention for clients

Employment Specialists and their Supervisors expressed that the strong links with mental health services helped keep clients in their job placements for longer than would have been possible without such integrated support. It was felt that many clients that the Employment Specialists worked with would not have retained their positions without the dual support of mental health teams and the EmployAbility services. Employment Specialists noted that they became more skilled at noticing when a client started to become unwell in work, and that they were able to quickly link in with mental health teams when this occurred. Employment Specialists felt that the skill exchange between both the MDT and the EmployAbility service was highly complementary and worked very well in terms of keeping clients in their placements. Employment Specialists said that because they

had a greater understand of the participant's background, including their mental health situation and clinical notes, they could provide much better support for participants.

Benefits to the State

The Department of Employment Affairs and Social Protection's recent report on its Disability Allowance (DA) Survey identifies significant levels of interest among individuals on DA in taking up employment, including both part time and full-time work. Among those who were not currently working 35% expressed an interest in working part time, while 8% expressed an interest in full time employment, given the right supports. The survey shows that 50% of participants reported mental health difficulties as the primary reason for being on DA. The survey also identified that people with disabilities (including mental health disabilities) experience numerous barriers to employment and a range of supports are required to help achieve employment ambitions and goals, including in areas such as being able to retain social welfare payments, supportive work environments, access to transport, mental health supports, adaptation of job tasks, flexible hours and flexible work arrangements.

The IPS model can contribute to the achievement of employment goals set out under the Government's Comprehensive Employment Strategy, which sets out a strategic approach by Government over 10 years to ensure that people with disabilities who want to work in the open labour market are supported and enabled to do so.

The IPS model also has huge potential for the Department of Employment Affairs and Social Protection to see how it can reduce the numbers of individuals with a severe mental health difficulty who are wholly-dependent upon social welfare for their income and how it can better support their employment.

Summary

The overall aim of the IEMHS project was to test the viability of delivering an IPS service to people receiving mental health services through interagency collaboration between HSE mental health teams and EmployAbility services, in partnership with the Department of Employment Affairs and Social Protection. The project management, training and other direct costs were funded by Genio. To achieve this aim, the project worked to four specific objectives:

1. To improve integration between public mental health and supported employment services at national level.
2. To improve integration between public mental health and supported employment services at local level.
3. To support 80 individuals receiving mental health services into employment, 20 individuals in each of 4 sites.
4. To increase the capacity of participating supported employment service staff and mental health service staff to support individuals with severe mental health difficulties.

The IEMHS project provided training and support to four IPS site teams in order to build capacity for implementing evidence-based supported employment. Participants in the training included MDT members, Employment Specialists and their supervisors, mental health area management team members and Departmental staff. Initial training gave staff members the theory and knowledge to operationalise an IPS service in their local areas. Over the two years that the project operated, the capacity of these staff members to deliver an IPS service for people with mental health difficulties significantly increased. The IEMHS project gained momentum as the project developed and staff were capable of delivering, across all sites, an IPS service that met the requirements of the IPS Fidelity Scale, with three sites achieving good fidelity and all sites improving their fidelity during the timeframe of the project. The project has successfully met the objective of building IPS knowledge and skills in staff across all four sites.

The IEMHS project has also achieved successful integration between public mental health and supported employment services at both local and national levels. Across four separate sites, Employment Specialists from EmployAbility companies were successfully integrated into HSE mental health teams to the standard set out in the IPS Fidelity Scale. Each site successfully delivered the IPS model, in line with the IPS Fidelity Scale and all sites successfully placed and supported clients into mainstream, paid and competitive employment.

In total, 95 participants were involved in the IEMHS project, which exceeds by 15, the number of participants the project set out to engage with. All 95 participants were supported to obtain employment and 36% of participants were successful on at least one occasion. This fulfils the final objective set out at the beginning of the project.

Recommendations

- A second phase, national IPS pilot should be carried out, in line with the recommendations made by the Centre for Mental Health. These recommendations are that at least two IPS sites and a control site work with 200 service users each, over 2 years, and that the job outcomes and estimated benefit savings are compared, along with follow-up data on the service users from this project, to establish how many appear to have reduced their use of mental health services compared with use of services in the previous 5 years.
- Any further IPS pilot should take full advantage of the data sharing protocols that are already in place as a result of the IEMHS project in order to capitalise on work already completed.
- Any further pilot should utilise at least two Employment Specialists per site, in line with the recommendations set out by the Centre for Mental Health.
- The salary scale for Employment Specialists should be set at such a level that will attract candidates with significant experience in job coaching as well as strong local knowledge of the employment opportunities and employer contacts in the area of work.
- In order to benefit from the supported employment experience of EmployAbility services, Employment Specialists should be supervised by an employment supervisor in the EmployAbility service.
- Training and mentoring should be provided for Employment Specialists by the Community Mental Health Team in order for Employment Specialists to become accustomed to local practise, particularly the management of clinical files and notes.
- IPS training should be provided for the whole IPS team, which includes the whole MDT, EmployAbility staff and supervisors and area management teams. Providing training in this way was central to the success of the IEMHS project.
- Full engagement of the local mental health area management is crucial to attaining full IPS fidelity. Local mental health and EmployAbility management should be engaged with from the very beginning of the project in order to ensure their leadership role in implementation is fulfilled.

Appendixes

Data Sharing Protocol

[Letterhead of the Employability company]

Integrating Employment and Mental Health Supports Project

Confidentiality Agreement

I, _____, an employee of [Employability company], understand that

during the course of my work on the Integrating Employment and Mental Health Supports (IEMHS) project, I may come in contact with personal information about mental health service users for the purpose of providing an integrated mental health and employment support service. I am aware of my obligations under the Data Protection Acts [1988], [2003] and the Freedom of Information Act [2014].

I commit to:

1) Keeping that information confidential except where required in order to carry out my regular duties;
2) Providing copies of all information to the HSE upon request or when no longer required;
2) Should I be given any personal information to take off site, I will ensure the files or electronic storage device will be kept secure at all times;
3) Complying with all the HSE's IT Policies which are in place.

In consideration of the mutual promises and agreements of the parties hereto, it is hereby furthermore agreed as follows:

I shall be responsible in gaining written permission from the service user to:

- Attend Recovery Care Plan meetings
- Share agreed defined information on Individual Placement Support to potential employment support agencies
- Share current mental health status with agreed employment support service
- Share current level of occupational functioning with agreed employment support service
- Share previous work concerns both past and present with agreed employment support service
- Share sensitive information concerning future work placements with agreed employment support service

I also understand that, under the Data Protection Acts, personal information obtained as part of the project must be:

- Obtained and processed fairly
- Accurate, complete and kept up to date
- Obtained only for one or more specified, explicit and legitimate purpose
- Kept safe & secure
- Shall not be processed in a manner incompatible with these purposes
- Adequate, relevant and not excessive
- Shall not be kept longer than is necessary
- Should be controlled with appropriate security measures

I confirm that I have read the following:-

- HSE's Data Protection guidance document *Data Protection – It's Everyone's Responsibility: An Introductory Guide for Health Service Staff,* and
- HSE's National IT Policies & Standards

And that I understand what is required of me as an Employability [title/location of company] employee working on the IEMHS project to ensure compliance with Data Protection Legislation.

Signed: _____

Name: _____

Title: _____

Line Manager: _____ **Date:** _____

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

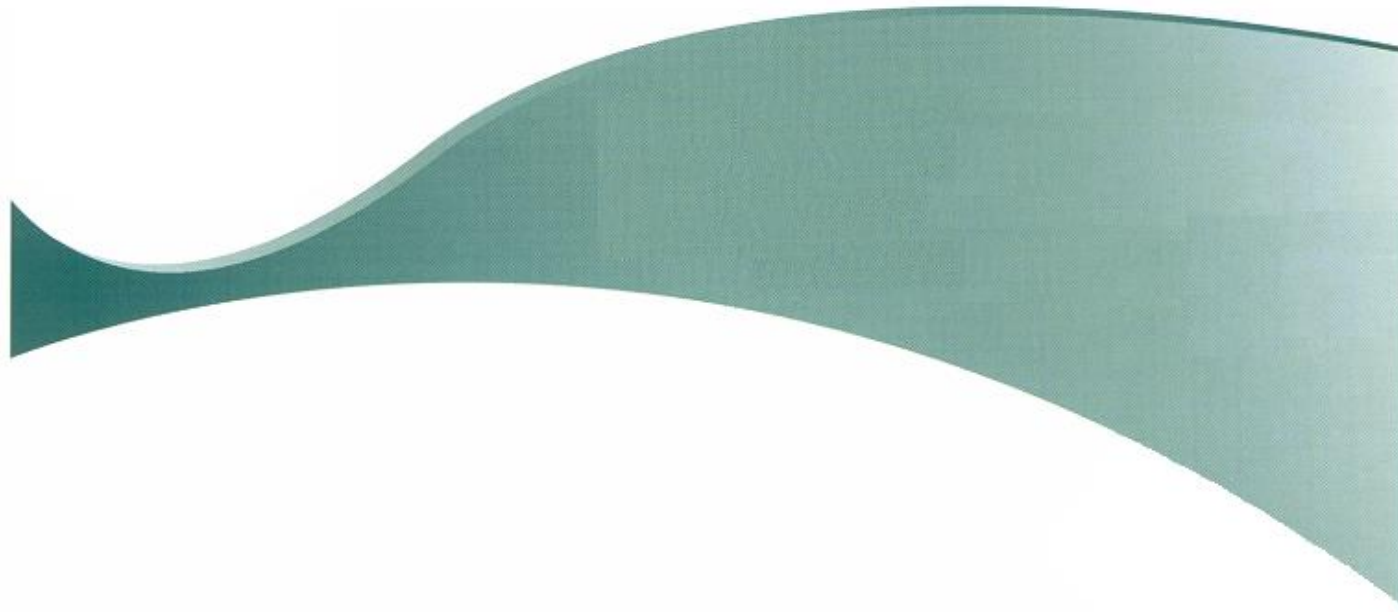
Data Sharing Agreement

Between

<< Health Service Provider Name >>

And

The Health Service Executive



1. Introduction

The purpose of this Agreement is to define the arrangements for the sharing of data between the Health Service Executive (HSE) and the specified organisations.

2. Definitions

For clarity, you should include a list of definitions / terms that are used throughout the Agreement.

In this Agreement, unless the context otherwise requires:

Anonymisation shall mean the process of rendering personal data into an irrevocable form which does not identify any individual and can no longer be linked to an individual.

Data shall mean any information (irrespective of the format it is held - paper, electronic or otherwise) of whatever nature that, by whatever means, is shared by the parties to this Agreement with each other.

Data Sharing shall mean the disclosure of data from one party to this Agreement to one or more other parties to this Agreement. It can take the form of systematic, routine data sharing where the same data sets are shared between the same organisations for established purposes; and exceptional, one off decisions to share data for any range of purposes.

Data Subject shall mean the individual who is the subject of the personal data.

Deleted shall mean removing all data (irrespective of the format it is held - paper, electronic or otherwise) in such a way that it can never be retrieved.

Personal data shall mean information relating to a living individual who is or can be identified either from the data or from the data in conjunction with other information that is in, or is likely to come into, the possession of the data controller.

Process shall mean performing any manual or automated operation or set of operations on the data including:

- Obtaining, recording or keeping the data;
- Collecting, organising, storing, altering or adapting the data;
- Retrieving, consulting or using the data;
- Disclosing the data by transmitting, disseminating or otherwise making it available;
- Aligning, combining, blocking, erasing or destroying the data.

Sensitive personal data shall mean personal data consisting of information as to a person's racial or ethnic origin, their political opinions or the religious or philosophical beliefs, whether they are a member of a trade union, details about their physical or mental health, and details about their sexual life.

3. Parties to the Agreement

This section of the Agreement should identify clearly all the organisations that are party to the Data Sharing Agreement.

You should also include:

(1) The contact details of the lead staff from each organisation that are directly involved in managing the data sharing arrangement.

(2) Procedures for including additional organisations in the data sharing arrangement and for dealing with cases where an organisation needs to be excluded from the sharing.

3.1 The following organisations are party to this Agreement:

a) The Health Service Executive, a body corporate with perpetual succession established by the Health Act 2004 (the HSE), and

b) [Organisation name] which has its principle administrative offices at

…….

3.2 The data sharing agreement will managed by the following staff from each of the participating organisations:

a) The Health Service Executive

Mr / Mrs. ……
Location: …….
Ph: ……...
Mobile: ……
Email: ……..

b) [Organisation name]

Mr / Mrs. ……
Location: …….
Ph: ……...
Mobile: ……
Email: ……..

3.3 If a new organisation joins the Agreement, a new version of the data sharing agreement will be issued as soon as possible, certainly within one month, and circulated to all participating organisations

3.4 If an organisation leaves the agreement, a new version of the data sharing agreement will be issued as soon as possible, certainly within one month, to all participating organisations.

4. Reason(s) for sharing data

This section of the Agreement should specify the reasons for sharing the data:

As a minimum you should include:

(1) Why it is necessary for the HSE and the [Organisation name] to share the agreed data,
(2) The specific objective(s) of sharing the data,
(3) The supposed benefits to sharing the data, and,
(4) How the HSE and the organisation will subsequently use the data

5. Description of data shared

This section of the Agreement should explain in as much detail as is possible the type of data that will be shared between the HSE and the [Organisation name]. As a rule only the minimum amount of personal data should be shared as is absolutely necessary in order to achieve a given objective(s).

As a minimum you should include:

(1) Type of data shared (i.e. personal data, sensitive personal data, anonymised data etc)
(2) Source of data shared (i.e. what systems is the data derived from)
(3) List of data sets & data items shared (i.e. patient name, address, DOB, UHI, MRN, medical records). If the list of data sets or data items shared is too large, you could include it as appendices.

6. Legal Basis for Data Sharing

It is essential that all personal data shared under the terms of this Agreement is done so in compliance with the following legislation:

(1) The Data Protection Acts 1988 & 2003
(2) European Convention on Human Rights Act 2003
(3) Common Law Duty of Confidentiality

Therefore, this section of the Agreement should explain the legal basis for sharing the data.

If the sharing of data between the HSE and the [Organisation name] is covered and permitted by legislation, (i.e. Data Protection Acts 1988 & 2003, Infectious Diseases (Amendment) Regulations 2011, Mental Health Act 2001, Education (Welfare) Act 2000, Health Act 2004, Health (Provision of Information) Act 1997, Adoption Act 2010, Child Care Acts 2001, 2007 & 2011, Children Act 2001 etc), then you will need to state this.

If patient consent is to be the basis for sharing of the data, then you should include a copy of patient consent form in the appendices of the Agreement. You should also address issues surrounding the withholding or retraction of patient consent.

7. Methods Used for Sharing Data

This section of the Agreement should give specific details of the agreed method(s) used to transfer the data from the [Organisation name] to the HSE and vice versa.

As a minimum you should include:

(1) Description of approved methods for sharing data (i.e. register post, courier, secure fax, site to site VPN (Virtual Private Network), Secure FTP connection, TLS connection, encrypted email etc).
(2) The agreed frequency of data transfers (i.e. daily, weekly, monthly, ad-hoc etc).
(3)Agreed security controls in place for each method used to transfer data.
(4) If relevant, also indicate any methods of sharing which are not acceptable under the Agreement.
(5) The format (i.e. paper, electronic, removable storage media, computer system, secure server etc) that the data will be held in once the data has been shared.

8. Data Quality

8.1 Each party to this Agreement shall be responsible for the quality and accuracy of the data, personal or otherwise, they share with the other parties;

8.2 Data discovered to be inaccurate or inadequate for the specified reasons (as defined in section 4 of this Agreement) will be brought to the notice of the party that supplied the data. The party that supplied data will be responsible for correcting the data and notifying all the other parties of the corrections.

9. Data Protection & Freedom of Information access requests

9.1 If one party to this Agreement receives a data subject access request, and personal data is subsequently identified as having originated from the another party, it will be the responsibility of the receiving party to contact the party that supplied the data to determine whether the supplier wishes to claim an exception under the provisions of either the Data Protection Acts 1988 & 2003 or Freedom of Information Acts 1997 & 2003. The receiving party must be mindful of the fact that they have 40 days under the
Data Protection Acts 1988 & 2003 and 20 working days under the Freedom of Information Acts 1997 & 2003, to respond to such requests.

10. Restrictions on the use of data shared

9.1 All data shared by the parties to this Agreement, personal or otherwise, must only be used for the reason(s) specified at the time of disclosure(s) and as defined in section 4 of this Agreement. The data must not be used for any other reason(s) without the permission of the party who supplied the data, unless an exemption applies within the Data Protection Acts 1988 & 2003 or the data is required to be provided under the terms of the Freedom of Information Acts 1997 & 2003 or under the instructions of a court of law.

11. Responsibilities of each party

In consideration of the parties sharing data with each other, each party agrees that it shall:

11.1 Process all personal data shared in accordance with the Data Protection Acts 1988 & 2003 and any guidance issued by the Data Protection Commissioner;

11.2 Maintain the security and confidentiality all of personal data;

11.3 Ensure the security of all personal data stored on all fixed and mobile devices, including desktop computers, servers and mobile computer devices (i.e.laptops, notes, tablets, personal data assistants, Blackberry enabled devices, iPads, iPhones and other smart type devices etc) and removal storage devices (i.e. CD, DVD, portable hard drives, USB memory keys, Diskettes, ZIP disks, Magnetic tapes etc);

11.4 Ensure that non-electronic personal data is managed and stored securely;

11.5 Implement appropriate human, organisational and technical controls to protect against unauthorised access, accidental loss, destruction, damage, alteration or disclosure of personal data;

11.6 Ensure that personal data is only accessible to their staff on a need to know basis;

11.7 Ensure their staff, that need to share personal data under this Agreement are given appropriate training and made fully aware of their responsibilities to maintain the security and confidentiality of personal data;

11.8 Not transfer any personal data outside the European Economic Area (EEA) except with the prior written consent of the party who supplied the personal data.

11.9 Ensure that personal data (irrespective of the format that the data is held, i.e. paper, electronic or otherwise) is retained no longer than is necessary;

11.10 Ensure that all personal data (irrespective of the format that the data is held, i.e. paper, electronic or otherwise) that is no longer necessary, is deleted and disposed of in a secure manor;

11.11 Inform the other parties, within 72 hours of any actual or suspected breach in their security, which could give rise to the actual or potential loss, theft, unauthorised release or disclosure of personal data or any part thereof.

12. Monitoring & Review

12.1 This Agreement will be formally reviewed on an annual basis by all parties to this Agreement, unless legislative changes necessitate an earlier review.

12.2 This Agreement may not be supplemented, amended, varied or modified in any manner except by an instrument in writing signed by a duly authorised officer or representative of each of the parties hereto.

13. Indemnity

13.1 The parties to this Agreement, agree to indemnify each other, against any action arising out of their failure to act within the terms of this Agreement, or in relation to wrongful or negligent disclosure of data generally relating to actions taken in the context of this Agreement

14. Governing Law

14.1 This *Agreement* will be governed by and construed in accordance with the laws of Ireland, and the parties submit to the exclusive jurisdiction of the Irish courts for all purposes connected with this *Agreement*, including the enforcement of any award or judgement made under or in connection with it.

15. Severance & Unenforceability

15.1 If any provision, or part thereof, of this agreement shall be, or is found by any authority, administrative body or court of competent jurisdiction to be, invalid, unenforceable or illegal, such invalidity, unenforceability or illegality shall not affect the other provisions, or parts thereof of this Agreement, and of which shall remain in full force and effect.

15.2 If any invalid, unenforceable or illegal provision, or part thereof, would be valid, enforceable or legal if some part were deleted, the provision, or part thereof, will apply with whatever modification is necessary to given effect to the intention of the parties as appears from the terms of this agreement.

16. Termination

16.1 A party to this Agreement can terminate their participation in this Agreement by providing the other parties with one month's written notice.

IN WITNESS where of this *Agreement* has been entered into the day and year first herein written.

SIGNED on behalf of the
Health Service Executive

…..
Signature

…..
Name (printed)

…..……
Title

In the presence of

…..
Signature

…..
Name (printed)

…..
Title

SIGNED on behalf of the
[Organisation name]

…..
Signature

…..
Name (printed)

…..
Title

Date: …….....

In the presence of

…..
Signature

…..
Name (printed)

…..
Title

Date: …….....

Key Fidelity Action Plan Points

Site	Key Fidelity Action Plan Points
Cork	• Site to make improvements in how specific fidelity areas are documented • Employment Specialist will deliver a presentation to Area Management Team to improve understanding of IPS at that level • More regular meetings between Employment Specialist and Coordinator to take pace
Galway	• Site to pay closer attention to documenting their IPS processes in order to achieve better fidelity. • The Employment Coordinator will attend a regular meeting slot with the MDT which will increase their fidelity. • There will be a more concerted effort made to engage with the Area Management Team by making use of the management team members that work in the Galway area.
Mayo	• The Employment Specialist will initiate a Jobs Club every Wednesday morning. • The Employment Specialist will schedule more than one meeting with clients per week which helps to increase the rate of job searching. • The Employment Specialist will log all Employer contacts in Google Calendar. • As part of the area of Job Development the Employment Specialist will make contact with employers regardless of whether they have a vacancy advertised or not. • The Employment Specialist will start “job carving”. • The Employment Specialist will log all contact with clients in an Outlook Calendar as well as in the Client files. Outreach attempts by MDT members with clients will be logged in this Calendar also.
Cav/Mon	• Site to pay closer attention to documenting their IPS processes in order to achieve better fidelity. • The Employment Specialist will develop new forms to track regular employer contact. • The Employment Specialist will develop a range of posters to market the IPS programme in the local area.

Centre for Mental Health Report

Integrating Employment and Mental Health Services: An analysis of outcomes and cost-benefits

Background

IPS was developed in the United States in the 1990s and has been replicated and successfully demonstrated as delivering better employment outcomes than traditional vocational services in many other places including the UK, Norway, Denmark, Hong Kong, Canada, New Zealand and Australia.

The IPS approach is defined by a fidelity scale of 25 items. Services scoring at least 100 out of a maximum 125 (80%) are said to be 'high fidelity' services and almost always demonstrate outcomes of at least 45% of people obtaining paid work. Lockett et al. (2016) looked closely at whether the fidelity score is a reliable means of predicting a quality service. They found that low or fair fidelity (under 80% score) was always associated with less than 45% job outcomes. A small number of high fidelity services have also failed to achieve this benchmark, meaning that high fidelity is a key indicator of quality, but other factors affecting job outcomes may need to be addressed, such as staff training.

The Integrating Employment and Mental Health Service (IEMHS) project placed one Employment Specialist from Employability services in each of four Multidisciplinary Mental Health Team sites in Ireland to support 20 people at each site. The four sites were Cavan/Monaghan, Castlebar in County Mayo, Galway and Bantry in West Cork.

A central objective of the IEMHS project was to improve integration between public mental health and supported employment services at national and local levels.

An editorial in the British Journal of Psychiatry in 2013 summarised the key barriers to wider implementation of IPS into three categories:

- Attitudinal barriers relating to the beliefs of both clinicians and employers;
- Contextual factors relating to the structure of the labour market and welfare systems;
- Organisational factors within mental health services (Boardman and Rinaldi, 2013).

Effectiveness

There were 95 participants involved in the IEMHS project; of these, 29 (31%) have had at least 1 job placement and 4 people had a second job placement. The first participants for the project began to be recruited in late August 2015, in the case of three sites, and February 2016 in the case of Castlebar. Recruitment continued through to the end of December 2016. Support continued until May 2017. Support continued until May 2017. The

participants were on the caseload of the Employment Specialists for between 2 months and 22 months.

	Cavan/Monaghan	Castlebar	Galway	Bantry
All Participants	22	21	23	29
Active Participants at end of project	18	14	13	20
Number in employment at end	9	0	2	13

IEMHS can be compared with '100 People' a pilot project undertaken in London, and a new high fidelity IPS service established in 2015, in Lincolnshire, as part of the 'Making IPS Work' project which was funded by the UK Department of Health 'Innovation, Excellence and Strategic Development' funding.

The '100 People' Project in London aimed to implement the Individual Placement and Support (IPS) model, modified for delivery through Jobcentre Plus (JCP) and a Work Programme Prime Provider (PP). The project focussed on employment support for up to 100 people living in London with schizophrenia, bipolar or psychosis, to find paid, competitive employment. The Employment Advisors (EAs) were not located in local mental health treatment teams, but aimed to collaborate with them to support people with mental health needs into employment (Hamilton, et al 2016)

In '100 People' during the period beginning September 2015 to the end of July 2016, 64 people received support through the project. Eleven people (17.2% of the caseload) had found employment by the end of the project, with 18 job outcomes overall (7 individuals had 1 job outcome; 1 individual had 2 job outcomes; and 3 individuals had 3 job outcomes).

In Lincolnshire, the IPS service comprising 2.5 full-time equivalent staff worked with service users of the secondary care mental health trust from February 2015. After 12 months, the service had received 120 referrals and achieved 40 job placements (i.e. 33%), 65% of which were sustained for at least 6 months.

The '100 People' project was able to compare its 17% successful job entrants with 9.5% achieved by the England and Wales Department of Work and Pensions programme (Mind, 2015). This is, however, relatively low in the context of IPS services evaluated through randomised controlled trails. Burns, et al. 2007, studied success rates for one day or more in employment achieved in a six-site European trial, which included one UK site. Under trial conditions the IPS schemes achieved successful employment outcomes for 55% of participants compared to 28% of trial participants receiving the best alternative vocational support.

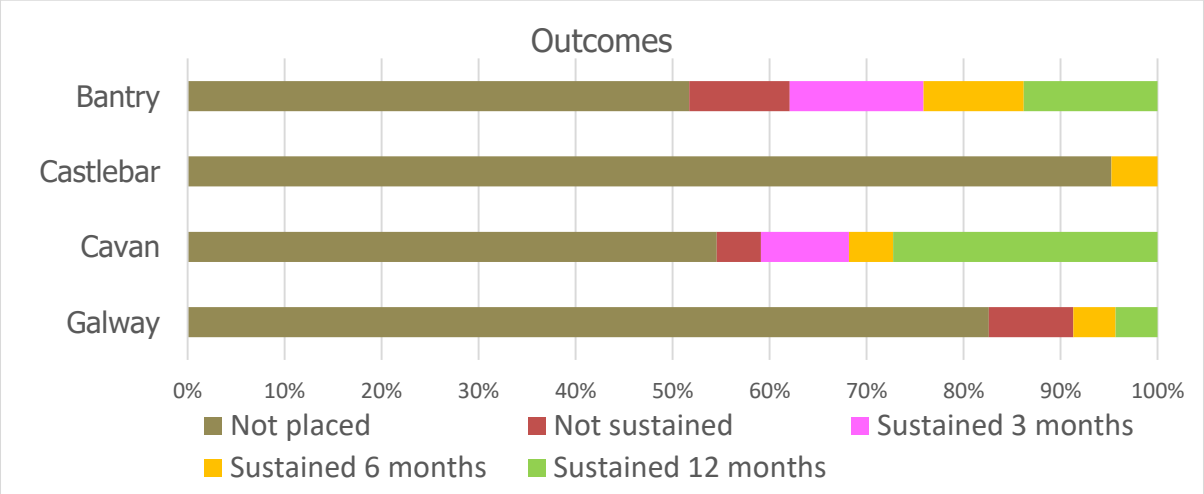
Bond, et al. (2008) reviewing 11 RCTS including two outside North America found mean employment outcomes for IPS were 61% compared to 23% for control interventions.

Outcomes

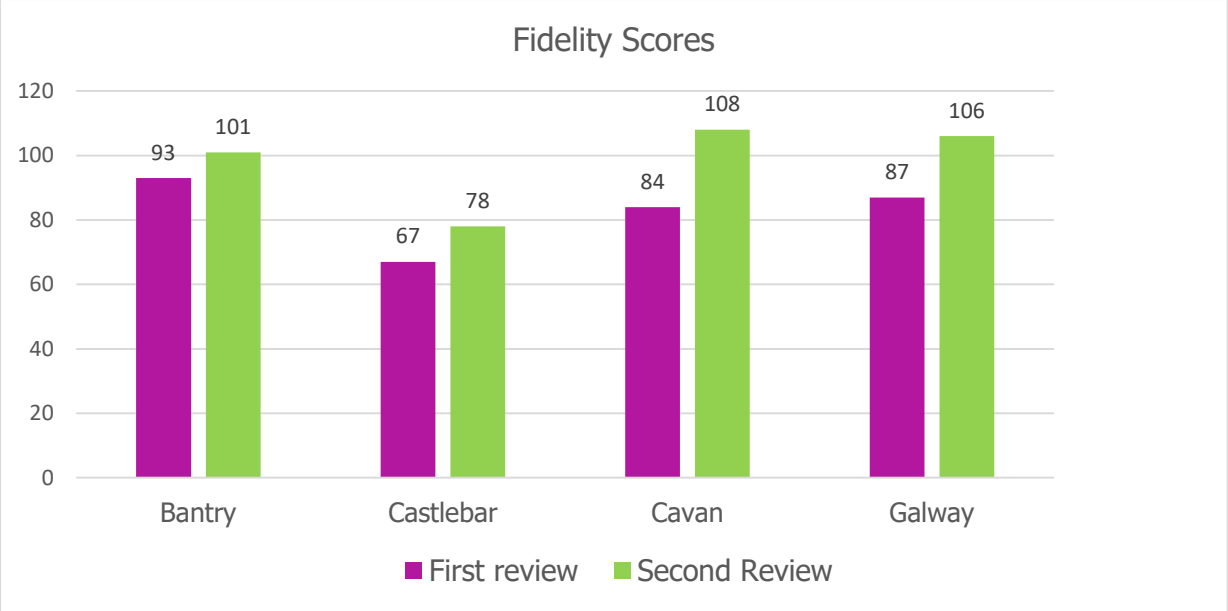
The four IEMHS had varied results, which correlated to some extent with the fidelity scores, but not entirely.

There were 95 participants overall, 29 participants achieved at least one job placement, 4 of the 29 achieved more than one placement.

The percentage of placements and sustainability are shown below, demonstrating that results for Bantry and Cavan/Monaghan were significantly better than those in the other two areas.



The fidelity scores for Castlebar were lower, but scores for Galway were fairly similar to the sites that achieved higher job placements:



Value for money

A report in 2014 (van Stolk et al. 2014) estimated the benefit-cost ratio for IPS in UK as £1.41 saved in government spending for every £1.00 spent on IPS, assuming that the person moved from out of work benefits into paid employment for a period of six months.

There might also be a saving in expenditure on health service use, achieved through recovery facilitated by employment. In a six-site European randomised controlled trial, the EQOLISE study, the participants randomly assigned to IPS were 60% less likely to have been admitted as a psychiatric inpatient over the final 6 months of follow-up. Additionally, being in work for more than 90 days was associated with an 18% reduction in the likelihood of becoming an inpatient on a mental health ward (Burns et al. 2009, Burns et al. 2007). Another study (Catty et al. 2008) found that 11% fewer participants in the IPS group than the control had been admitted to hospital.

To date, the literature about the cost-effectiveness of IPS does not demonstrate clear conclusions. While a number of studies have been conducted to assess the cost-effectiveness of IPS programmes (Salkever, 2010), most of these were conducted in the US and suggest a per client cost of between $3,500 and $5,000 in the initial year. Bond reported figures of $5,500 dollars per client in the US in 2012.

A recent (unpublished) benchmarking audit of IPS in England concluded that the average cost of providing an IPS service is £1,700 per person and the average cost per job achieved is £3,777, before any additional savings of relinquished benefits are factored in.

In '100 People', a cost-benefit analysis was based on the financial information available, which was in the main similar to that data available for the IEMHS service, i.e. salary costs and government-administered benefits savings.

The authors of '100 People' point out that their conclusions should be treated with caution, and the analysis falls short of taking into account all the direct and indirect costs of delivery, all benefits affected by employment income, and broader savings (e.g. through reduction in service use).

Another important consideration applicable to these services is that there was no control group, and analysis assumes that no job outcomes would have been achieved in the counter-factual, i.e. that there would have been no job outcomes achieved by service users undertaking job seeking alone, without funded support.

The staff costs for '100 People' were £57,533. The project helped secure employment for 11 customers. This gives a cost per employment outcome of £5,230. Of these 11 customers, five continued to claim income support benefits at the same rate as before. The total savings in benefits for the remaining six customers was £16,966.

This produced a net cost for the Department of Work and Pensions of £40,566, and a net cost per employment outcome of £3,688. However, all but one of these jobs were continuing at the end of the project, so savings will accumulate over time. It is not possible to give a figure for this longer-term saving since we do not know how long employment was sustained. Apart from job outcomes, other progress towards employment was evidenced by the numbers of job applications and interviews. Both employment advisers and customers reported improvements in confidence and skills as a result of the project. One customer, who had not had a job in over twenty years, was attending multiple interviews by the end of the project.

In order to reach a net saving, the authors calculated that these customers would need to sustain employment at the same level for just over 2 years. This does not take into account the likelihood that hours and pay would increase over that time. But, on the other hand, data on other monetary benefits still being received was not obtained (e.g. housing benefits).

For IEMHS the staff costs over the period totalled €212,769. Project expenses, such as travel, phone, equipment cost €19,509; added to this was ImROC consultancy and learning set costs at €17,084 and project management costs of €26,964, giving a total of non-staff costs of €63,557.

The combined staff and project costs totalled €276,326. This gives a cost per participant of €2,909 and an approximate cost per job outcome of €8,374.

If the start-up costs of ImROC consultancy and project management are excluded the cost per participant was €2,451 and the cost per job outcome was €7,057.

The average weekly wage for successful participants was approximately €230. 21% of successful participants had downward adjustments to their social welfare payments and 18% relinquished their social welfare payments entirely. 20% of successful participants utilised the Wage Subsidy Scheme (WSS).

Assuming that average savings in benefit claims each week during 2016 was €900, the total benefit savings for the project were €46,800, reducing the cost per person employed from €7,057 to €5,443; a figure around 30% higher than that achieved by the '100 People' project, when converted to Euro.

Project	Basic cost per job	Benefit savings per person	Cost per job after savings	% difference
100 People	5,955	1,755	4,200	Baseline
IEMHS	7,057	1,614	5,443	+30%

However, the above are averages and when analysed by individual site the results show a wide variation in value for money.

Site	Number of job placements	Basic cost per job	Benefit savings per person	Cost per job after savings	% difference
100 people	18	5,955	1755	4,200	Baseline
Bantry	15	3,881	1614	2,267	-46%
Castlebar	1	58,219	1614	56,605	+2397%
Cavan/Monaghan	13	4,478	1614	2,864	-95%
Galway	4	14,555	1614	12,941	+352%

Furthermore, there were other unquantified benefits from the IEMHS project. The Employment Specialists noted significant unanticipated secondary benefits for clients from their involvement in the IEMHS project. Employment Specialists recorded that many clients gained more independence either as a result of job searching, a job trial or a job placement. 5 out of 95 (5%) participants moved from supported accommodation to independent living during their participation in the IEMHS project.

Fidelity

The four sites were supported to improve their fidelity to the IPS model between the timing of the initial fidelity review and a later re-evaluation.

The second round of Fidelity Evaluations took place in March and April 2017. The results of these evaluations are displayed in the table below.

Fidelity scores showed that sites still lost marks due to insufficient executive team support, and inconsistent supervision of Employment Specialists. Three of the four sites were providing at least a 'good' level of fidelity at the time of the evaluations while Castlebar were providing a 'fair' level of fidelity. It is notable that it is not possible to achieve 100% fidelity in Ireland due to the different structure of its health services and employment support system. The IPS fidelity scale was developed to fit a UK health model which does not directly transfer to Ireland's current model. An Irish IPS fidelity scale, which caters more specifically to the Irish context could be considered.

Fidelity Evaluation scores per site

Sites	Cavan/Monaghan	Castlebar	Galway	Bantry
Score	108 (Good)	78 (Fair)	106 (Good)	101 (Good)

All employment specialists scored well on:

- Number on caseload;
- Zero exclusion of referrals;
- Support with benefits advice;
- Individualised job search;
- Diversity of employers.

Employment specialists had scored less well (and therefore provided an action plan to improve):

- Frequency of employer contact;
- Referrals from and frequency of contact with the CMHT;
- Partner clinicians' focus on IPS/employment;
- Executive team support for IPS.

Discussion

The four IEMHS Employment Specialists worked for almost two years with 95 people, retaining around 65 people active at the end of the project. The relatively short length of time that the project was operating militated against better results; for an ongoing service we would normally expect the team to work with more than 95 people over this time period. Due to caseload turnover, we could expect around 150 referred for IPS. Assuming that 35% job outcomes could be reached, this would have achieved work outcomes for 52 people and the average cost per job would have been 44% lower. It would also have been lower if higher benefit savings had been possible through jobs with longer hours, or higher pay. Hours, however, is dependent partly upon the aspirations of the individual, and hourly pay may be an unavoidable consequence of the current economic condition. Further issues were that the Cavan/Monaghan Employment Specialist took maternity leave and the Cork EmployAbility Coordinator left post.

Sustainment rates of participation were generally good, but masked the huge differences in actual numbers of people placed in the four areas.

	People placed	Not sustained	Sustained 3 months	Sustained 6 months	Sustained 12 months	% sustained at least 3 months
Bantry	14	2		1	1	50%
Castlebar	1	1	2	1	6	90%
Cavan	10			1		100%
Galway	4	3	4	3	4	79%

Conclusions

The large distances between the project sites meant that in reality there were four very small IPS services, rather than one project/service with four areas working in close parallel. In our experience it is very difficult for a single IPS worker (especially with external supervision) to achieve the hoped for numbers of referrals and sustained job outcomes. The 'Making IPS Work' project established in six sites in England had *at least* two Employment Specialists and an on-site IPS supervisor (holding half a caseload). These teams of 3-5 funded for 18 months by a grant were able to establish the service and ensure that partner clinicians and the executive team were aware and supportive of IPS and shared in the successes of each team achieving the target for job outcomes.

The project has demonstrated that IPS can be implemented to good fidelity within 12-14 months and that job outcomes approaching expected levels can be achieved. If the services had been staffed with 2-3 Employment Specialists to support one another, they may have been able to get closer to achieving job outcomes of around 35-40%.

The cost benefits of the IEMHS service are promising. Value for money would improve if higher number of service users claiming benefits could be helped into work of sufficient hours and pay to substantially reduce benefit claims.

As a proof of concept this experiment has been a success. Actual cost savings are difficult to calculate without an equivalent counterfactual (control site) but it is very reasonable to believe that few of the service users who had been out of work for over 9 years (or even at least 4 years) would have achieved an employment outcome without the IPS service supporting them.

As a next step, we recommend that at least two IPS sites and a control site work with 200 service users each, over 2 years, and that the job outcomes and estimated benefit savings are compared, along with follow-up data on the service users from this project, to establish how many appear to have reduced their use of mental health services compared with use of services in the previous 5 years.

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