SOCIAL FINANCE

European Social Catalyst Fund

Scaling employment support in Europe

Individual Placement and Support (IPS)

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Contents

Introduction

Employment is traditionally seen as an 'end goal' of recovery from mental health problems, rather than an integral part of the recovery journey itself. Individual Placement and Support (IPS) is changing this.

The assumption that people are not able to work until they have reached a certain stage in recovery has, along with other barriers such as widespread stigma and discrimination, meant that people with mental health problems are consistently disproportionately affected by unemployment and underemployment. OECD data shows that the employment and unemployment gap of people with a mental disorder has increased over the past decade.[1]

There is now a concern that people who are furthest from the labour market, such as those with severe and enduring mental health problems, will be further left behind in the recovery from the COVID-19 pandemic. The Institute for Employment Studies notes that employment gaps for disabled people, among other groups, are not reducing, despite increased vacancies.[2]

Research shows that people with severe mental illnesses who enter paid employment experience change in self-identity, improved quality of life and reduced symptoms,[3] and thus employment can play a vital role in recovery. Traditional employment support services for this cohort have typically focused on extensive pre-placement training and support with a strong emphasis on job preparation prior to starting job search. This has not proved an effective strategy to help people achieve employment in the competitive labour market.

By contrast, 'supported employment', a model that focuses on rapid job search, individualised employer engagement, and in-work support, has been shown in repeated trials to deliver far stronger outcomes.

At the end of 2020, Social Finance Netherlands and Social Finance UK were awarded funding from the European Social Catalyst Fund to work with five European countries to develop plans to scale a type of supported employment called Individual Placement and Support (IPS).

The project was carried out by a consortium of local IPS leaders in Croatia, the Czech Republic, Denmark, France and Spain who brought deep expertise to the scale-up challenge. Social Finance Netherlands acted as Grant Manager and Social Finance UK managed and coordinated the project, drawing on their expertise in IPS, scaling interventions and project delivery.

The IPS model

Individual Placement and Support (IPS) is a supported employment approach that was developed in the USA in the 1990s to improve employment outcomes for people with severe mental illness (SMI).[4] IPS relies on the rapid engagement of the individual with employment and a "place then train" approach. Employment Specialists[5] help people to find paid, competitive work in a role and sector that fits their needs, skills, experience and desires.

Since its inception, IPS has spread to at least 20 countries,[6] while 27 Randomised Control Trials across the world have proven it to be an effective intervention in a variety of settings and economic conditions.[7] IPS is more than twice as likely to lead to competitive employment when compared with traditional vocational rehabilitation.[8,9]

Our scaling ambitions & project aims

Over the course of eight months, each of the five countries conducted system and stakeholder mapping exercises to identify barriers and opportunities for IPS expansion in the current policy, cultural and financial contexts. They held meetings with key stakeholders, including current IPS clients and developed a detailed plan for scaling IPS over two years, including an approximate budget, delivery plan and expected outcomes.

Each of the five countries was starting from a very different point in their IPS journey. For example, IPS does not yet exist in Croatia but is present in almost half of the municipalities in Denmark. As a result, it was expected that each country would take a different approach to scaling IPS and would have different ambitions for how far it could get in a two year planning period.

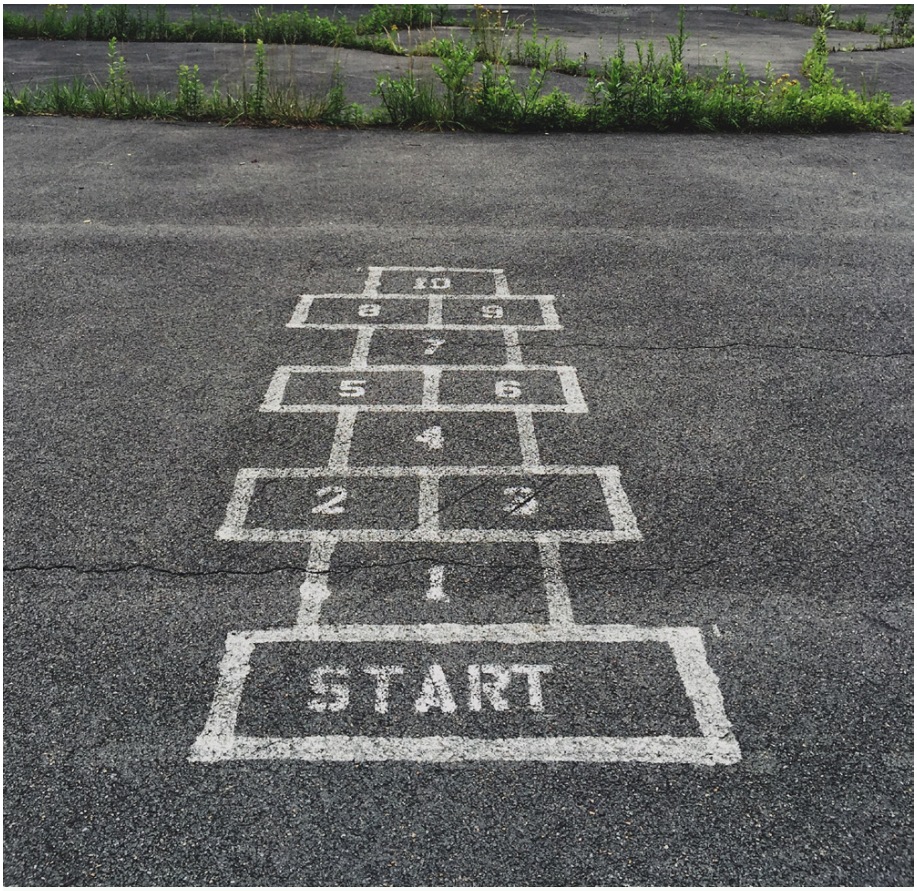
We used Social Finance's **Routes to Scale** framework[10] to explore the different potential building blocks for scaling IPS in each country. For example, achieving scale often requires a change in national policy, or a shift in accountability or incentives. However, achieving this can be a lengthy and highly unpredictable process. We chose to focus instead on four building blocks where we and the country teams could have the greatest impact:

1. Achieving widespread delivery of IPS
2. Supporting existing sectors to adopt IPS as a new way of working
3. Driving new or changed funding for IPS
4. Stimulating a new public conversation around mental health, disability and employment

The main body of this report focuses on the different routes to scaling IPS in Europe identified through this project. At the end we have included five key learnings we feel are relevant to scaling other evidence-based social interventions. Finally, the appendices give more detail on the IPS model and the specific country contexts and scale-up plans.

Acknowledgements

We would like to thank all partners involved in this project. The country plans included in this report have been produced by teams from the University Psychiatric Hospital Vrapče in Zagreb, the Centre for Mental Health Care Development in Prague, the Copenhagen Research Centre for Mental Health, Working First in Marseille and Fundación Avedis Donabedian in Barcelona.



Social Finance UK: Social Finance UK is a non-profit organisation based in London with extensive experience developing models, products and services that drive systemic change to improve people's lives, and pioneers of the Social Impact Bond. Social Finance has been working to develop the IPS model since 2014, and currently leads the national IPS roll-out infrastructure programme in England, **IPS Grow**.

Social Finance Netherlands: A sister company to Social Finance, SFNL also works to create innovative financing solutions to improve social outcomes, helping governments, non-profits and financiers to measure, finance and increase social impact.

University Psychiatric Hospital Vrapče: a leading psychiatric institution in Croatia that provides inpatient, outpatient and community treatment, including psychosocial rehabilitation. The hospital is also a teaching facility of the University of Zagreb.

The Centre for Mental Health Care Development (CMHCD): a non-profit founded in 1995, CMHCD works to support the transfer of mental health care from a hospital model into the community. CMHCD works on a range of projects including supporting IPS services in the Czech Republic.

Copenhagen Research Centre for Mental Health (CORE): CORE is a Danish multi-disciplinary research centre with a broad focus. The overall purpose is to treat and care for patients using evidence-based methods derived from research rooted in clinical practice.

Working First: Working First is a non-profit based in Marseille which works to promote empowerment, recovery and advocacy through the employment of people living with mental illnesses and social issues.

Fundación Avedis Donabedian Para La Mejora De La Calidad Asistencial (FAD): a non-profit based in Barcelona with more than 20 years' experience in projects aimed at improving the quality of health and social care services, nationally and internationally. Since 2013, FAD has also been part of the IPS International Learning Community.

This project was made possible by the support of the European Social Catalyst Fund (ESCF). The ESCF is established and co-funded by the Horizon 2020 European Union Funding for Research and Innovation, Genio, Robert Bosch Stiftung and the King Baudouin Foundation. It aims to stimulate and support creative ways to scale up proven innovations to produce good outcomes cost-effectively.

We would particularly like to thank Genio for their support running workshops and providing various resources throughout the project.

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This report was written by Jessica Hughes-Nind and Gary Johnston.

What are the opportunities for scaling IPS in Europe?

£6,000

The per person per year saving delivered by IPS to the mental health system

This chapter explores why IPS is a good employment model to scale, what the barriers are and how we can scale IPS in Europe.

IPS is an ideal candidate for scale...

There is significant evidence that appropriate, fulfilling work promotes recovery for people with severe and enduring mental health conditions. Most people with severe mental illnesses (SMI) report that they want to work.[11] However, people with severe mental illnesses are consistently much less likely to be in employment than those without: a literature review from 2004 showed that only 10%–20% of patients diagnosed with schizophrenia in Europe were employed,[12] while a 2006 Italian study found the employment rate of patients with SMI to be only 6%.[13] In England, only 9% of adults in contact with secondary mental health services are in paid employment.[14]

Data suggests that 55% of people with mental health problems who fall out of work never return to work. Of those who return, 68% have less responsibility, work fewer hours, and are paid less than before.[15] People with mental health conditions are exposed to greater instability and insecurity in the labour market with a knock-on effect on social vulnerability, exclusion and poverty. This was seen in the COVID-19 pandemic, where people with existing mental health conditions who were in work were more likely to be employed in sectors that had to close due to restrictions, and thus lose their jobs.[16]

To ensure everybody has an equal opportunity to access employment, better employment support for people with mental health problems is needed.

IPS is an internationally tested, evidence-based intervention which has been proven to do this effectively; a 2008 review of the literature on its effectiveness found an average competitive employment rate of 61% of IPS clients compared to 23% of those in the control group.[17] As well as outcomes for the individual, IPS also delivers benefits to taxpayers and society. One UK analysis suggested that IPS could deliver a per person saving of up to £6,000 per year to the mental health system.[18] Supporting someone on disability employment benefits in the UK into work can save £12,000 per year in tax and benefits.[19] This is compared to an average cost of running an IPS service of £1,300 per person engaged per year.[20]

There are few social interventions that can boast an international evidence base built up over three decades; a powerful social case, based around supporting mental health recovery; and a strong economic case, built on tax, benefits, and healthcare savings. These three planks make IPS an ideal candidate for replication and scale.

...but there remain many barriers

Despite this, few countries have achieved large-scale growth of IPS since its inception 30 years ago. The diagram on the following page shows an overview of the provision of IPS in each country involved in this project as of early 2021. In all countries, IPS is free to access for the client.

Why has IPS not reached widespread scale yet?

We have identified seven key factors that may explain why IPS is not yet widespread in most countries:

1) **Government policy:** Despite the extensive evidence behind IPS, government policy does not recommend IPS as the preferred employment support service for people with SMI in any of the five countries, and does not specifically mention the IPS model in national policy at all in France or Croatia.

This means regional and local governments are not encouraged to invest in IPS services over traditional employment services. In addition, as noted in Becker and Bond's paper on the international growth of IPS (2020), labour and disability policies in some countries are inconsistent with and provide a direct challenge to IPS fidelity.[21] For example, part-time work is rarely an option in Croatia.

"There are few social interventions that can boast an international evidence base built up over three decades; a powerful social case, based around supporting mental health recovery; and a strong economic case, built on tax, benefits, and healthcare savings"

Figure 1. The number of IPS services in country as of early 2021

France

The majority of the c.90 Supported Employment services in France do not refer to the IPS model.

A few 'IPS-inspired job coaching services' offer support to people with mental health problems who aren't recognised as disabled workers.

Services are not integrated with mental health services and there is no real IPS learning community. Fidelity to the IPS model is rarely measured (currently only measured by five services).

Denmark

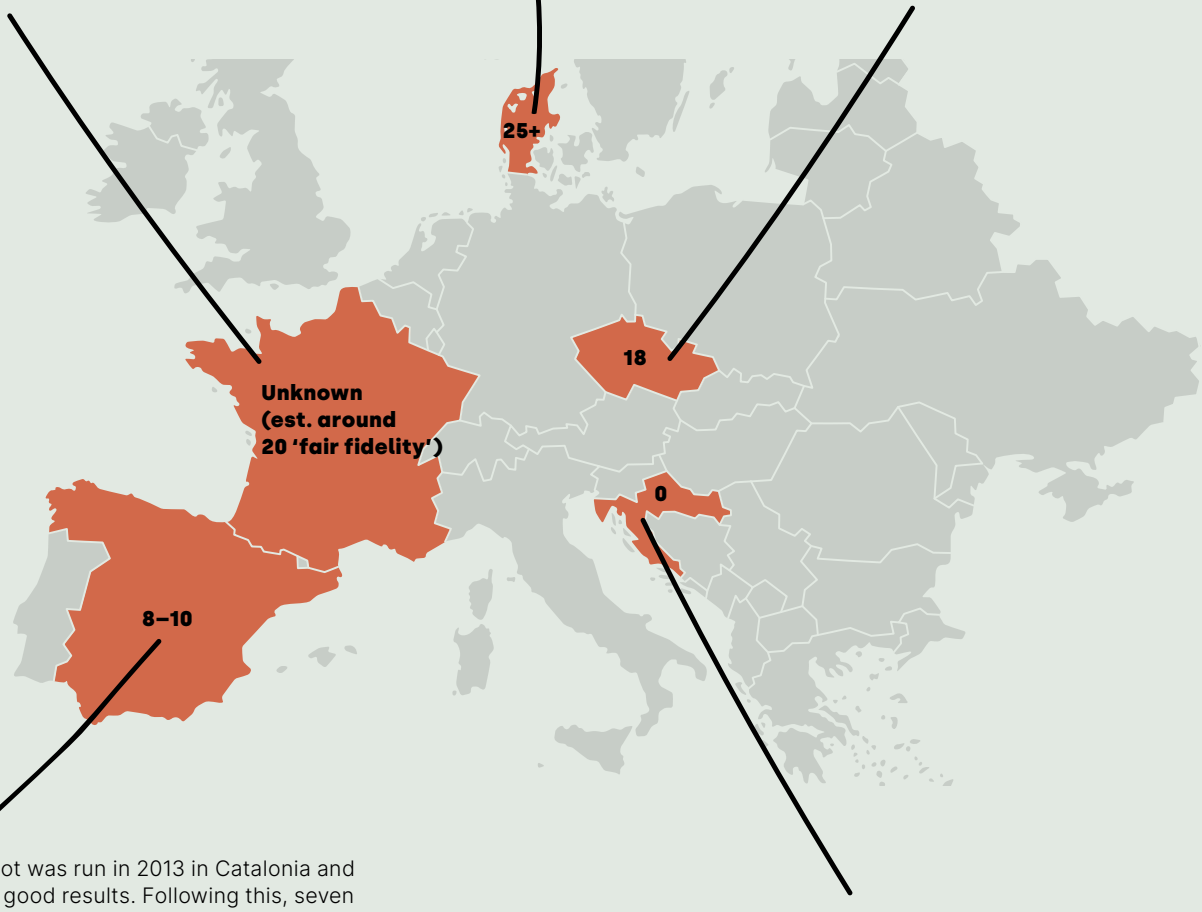
IPS was first introduced in Denmark in 2012 in a Randomised Control Trial funded by the Danish Agency for Labour Market and Recruitment. The trial had 720 participants and achieved good results. Since then, IPS delivery has steadily spread through Denmark. IPS is delivered in partnership with job centres in at least 25 municipalities in Denmark.

Training and support for IPS services is limited, and IPS is not yet recommended at a national policy level.

The Czech Republic

There are currently 18 IPS service providers in the Czech Republic, all of which are NGOs. IPS is well integrated into the mental health team or mental health centre where it is delivered and are delivered in the same settings as community mental health services.

Fidelity reviews are not common practice and it is therefore not clear which services deliver 'true' IPS.



Spain

An IPS pilot was run in 2013 in Catalonia and achieved good results. Following this, seven sites adapted their own programmes to implement IPS, participated in training and fidelity reviews and provided quarterly reports. Two further sites have been trained and done a base fidelity review.

Some organisations in Madrid and Murcia are trained to implement IPS. Andalusia and the Canary Islands have also moved towards IPS-like practice in recent years.

The Spanish Mental Health Strategy 2009-2013 supports IPS at a national level.

Croatia

There is currently no IPS in Croatia. Temporarily unemployed people with disabilities can be referred to occupational and social inclusion programmes by the Croatian Employment Service or Regional Vocational Rehabilitation Centres, which can provide up to 100 hours of support in the workplace for 12 months. There is currently no specialised service for people with SMI seeking employment.

2) **Stakeholder engagement:** Strong partnerships are key to achieving impact at scale. To scale high-quality IPS, buy-in is needed from a range of stakeholders, such as regional administrations, service delivery organisations and mental health professionals. The level of engagement across these stakeholders in each country varies and is currently a key blocker to the uptake of IPS in all countries we worked with. For example, we found psychiatric units being unable to get support from hospital administrators to run innovative programmes, regional governments refusing to fund supported employment services, and national Institutes for Disabled People favouring other services with a more immediate return on investment.

3) **Service integration:** There are cultural and structural disconnects between mental health services and employment support services in most countries involved in this project; for example, employment agencies may be reluctant to take on clients with mental health problems, or there may be no formal cooperation agreements between job centres and regional psychiatry services. This poses challenges to the IPS model, which relies on effective integration of the two to provide joined-up support that values employment as a key part of an individual's recovery.

4) **Funding:** Consistent funding is critical for achieving scale, but funding for IPS services is limited and, in some cases, only short-term and subject to change. Opportunities for unlocking new funding from government and private foundations are also limited by competing priorities and increased pressures following the COVID-19 pandemic. Moreover, the limited funding that is available is often given to traditional, non-evidence-based services instead of to IPS, and resistance to deviate from tradition or from the status quo makes reallocating funding difficult.

5) **Training and quality support:** The supporting infrastructure required to ensure that IPS services deliver high-fidelity IPS and achieve the best outcomes possible is not in place in any of the countries we worked with on this project and requires additional funding to set up and run. Even where governments are willing to fund IPS services, they are unlikely to fund this wider support in addition to the salaries of frontline Employment Specialists, despite the crucial role it plays in ensuring the quality and sustainability of IPS services.

6) **Stigma and low aspirations:** Employers, staff, mental health professionals and service users themselves too often have low expectations for the ability of people with mental health problems to work. Mental illness is still highly stigmatised in most countries. As a result of this stigma and low expectations, policy and funding is focused on less ambitious services, such as sheltered workshops and traditional support models that emphasise volunteering and training outcomes over competitive employment.

7) **Lack of local evidence and research:** proof that the IPS model is effective in the local context of each country has often been critical to gaining stakeholder buy-in in the development of IPS internationally,[22] and a lack of this evidence was identified as a key barrier to persuading governments to fund IPS services in several of the countries we worked with in this project. This is despite the considerable international evidence base that IPS already benefits from.

How can we scale IPS in Europe?

Responding to the challenges above, each of our country teams developed context-specific scale-up plans to progress towards widespread delivery and adoption of IPS, new funding and new public conversations about mental health and work. These plans show three distinct routes to scaling IPS in Europe:

Route A. Running a pilot to build the evidence base and challenge the status quo

In Croatia, IPS will be introduced via a small pilot service in Zagreb with two Employment Specialists.

IPS has not been run in Croatia previously, so a pilot is necessary to show how the model can work in the Croatian context and persuade key government and funder stakeholders that it is a cost-effective intervention. External funding would be needed to fund the two Employment Specialists. The Employment Specialists would receive training and supervision from the mobile psychiatric team, funded through national health insurance.

Outside of the IPS service, peer support workers will also be employed to provide additional support to people with mental health conditions looking for employment.

The scale-up plan in Croatia focuses largely on challenging the status quo, pushing a new public conversation about mental health and employment, and building the national evidence base of IPS. The team hopes that in running the proposed pilot, they will:

- Learn what is needed to better integrate employment and mental health support services in Croatia
- Influence social workers, mental health professionals, patients and their families to have higher aspirations for people with mental health problems who want to work
- Understand patient and family perspectives on the impact of IPS on their recovery
- Learn how to best engage employers with the IPS service

This plan aims to put IPS 'on the map' as a recognised and effective model for supporting people with SMI into work and begin to change the perspectives of professional, patients and the wider community. The expectation is that after the two years the two Employment Specialists will become permanent employees, with their salaries and training needs funded by the government.

Route B: Securing government funding to expand services to new areas

In the Czech Republic and France, where IPS is already partially established, IPS will be scaled by adding new services in multiple regions.

Within this route, the focus is on promoting wider adoption of IPS services by establishing new teams, reallocating funding and improving the quality of existing services.[23]

In the Czech Republic, two out of eight regional governments have agreed to fund IPS services of three and four Employment Specialists respectively. The governments will fund the running of the services from social services budgets, but additional funds will be needed for the training and wider quality assurance support. Two steering committees involving service users will be regularly informed and consulted about the development of the scale-up and how it can be implemented most effectively. The hope is that after the two years, the regional governments will not only continue to fund the new IPS services but will also allocate their own resources to the wider training and quality assurance support needs.

The team also hope to be able to explore opportunities to conduct and/or contribute to further research into the efficacy of IPS for people with common mental health problems.

In France, the plan is to use Supported Employment Platforms recently launched by the State Secretariat for Disabled People to disseminate the IPS model. These platforms will aggregate various job coaching and supported employment services that are not contracted by the state and will be set up autonomously at the departmental level. Each of these 'hubs' will receive funding from the central government and redistribute it among their partners. Working First plan to use this opportunity to promote IPS training and evaluation across France. A monitoring and evaluation committee would be set up including professionals and service users.

The hope is that these Supported Employment platforms will provide an opportunity to commission more IPS services and provide evidence for the benefits of IPS across different French regions.

The platforms also provide the opportunity to standardise a range of supported employment services to align with the IPS model. In the long-term, IPS services could be further disseminated through the public medico-psychological community centres, which are part of the national Mental Health System.

Route C: Establishing a national learning community and support network to improve the quality of existing and future services and share best practice

In Denmark and Spain, the scale-up plans include establishing national support networks and learning communities to support current and future IPS services.

Many countries, such as Japan, Italy and England, have formed such learning communities to promote and support IPS,[24] and have found these to be 'crucial for establishing new IPS programmes and maintaining existing ones'.[25] This route aims to support the widespread delivery of IPS and push a new public conversation by harnessing collective effort, improving the quality of services, and mobilising a shared voice.

In Denmark, the proposed Danish IPS Learning Community (DILC) will consist of implementation consultants in each of the five regions of Denmark, as well as permanently affiliated service user consultants, and will be supported by a team of IPS experts. The aims of the DILC will be to:

1. Expand the knowledge of IPS in Denmark and help push for implementation in all Danish municipalities
2. Support the implementation process in job centres and psychiatric outpatient clinics, from the decision to full implementation, including establishing cross-sectorial cooperation

3. Train Employment Specialists
4. Ensure the quality of IPS services nationally
5. Conduct further research and improvements of the IPS intervention in Denmark

The plan involves the five Danish regions each allocating resources for a regional implementation consultant and co-financing the expenses of the supporting personnel from CORE or a similar organisation, who will manage the daily operations of the DILC for three years.

As IPS services are already growing in number in Denmark, the hope is that the establishment of a DILC will ensure the sustainability of this expansion, and that after six to eight years 80% of all municipalities in Denmark will be delivering IPS.

In Spain, alongside setting up new IPS services in Andalusia and Madrid, and further developing existing services in Tenerife and Catalonia, the scale-up plan outlines a proposed IPS Spanish Network and Community of Practice. This network will be led by our Spanish partners in this project, FAD, and will aim to:

1. Put isolated IPS organisations in contact with each other
2. Share knowledge and experience of IPS in Spain, as well as information from the International and European IPS Networks translated into Spanish
3. Explore further opportunities for funding the model across Spain
4. Increase the visibility of IPS in Spain and continue to support the scaling up of the model
5. Collaborate with universities and research networks to carry out specific IPS research

Additional funding from private foundations and/or European funds will be needed for this. The hope is that through this network, current IPS services and their outcomes will become more visible to participating regional governments and other interested regions.

Following the two year plan, the team at FAD plans to open the network up to other regions interested in starting IPS training.

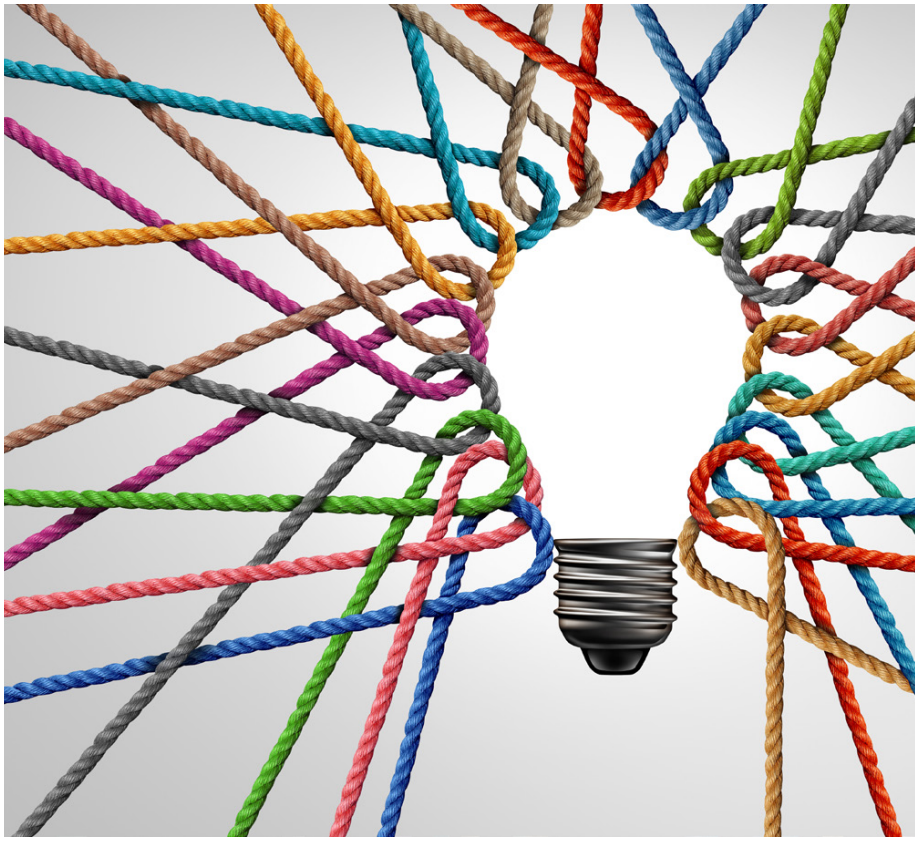
"During this project, we engaged a wide range of important IPS stakeholders in Denmark, including the ministry of health, labor market authorities, and government politicians. Recently, after the project ended, the political 10-year plan for psychiatry in Denmark was released, and IPS seems to have a significant role in future psychiatry. Now the big task is to go from declarations of intent to a national scaling of IPS which includes all people with mental illness who have a wish of employment."

Thomas Christensen, CORE

Across all three routes to scale there are common themes, such as shaping sector practice, altering or reallocating funding, and creating feedback loops through ongoing service user engagement in the design and implementation of the scale-up plans. In addition, all plans include details on:

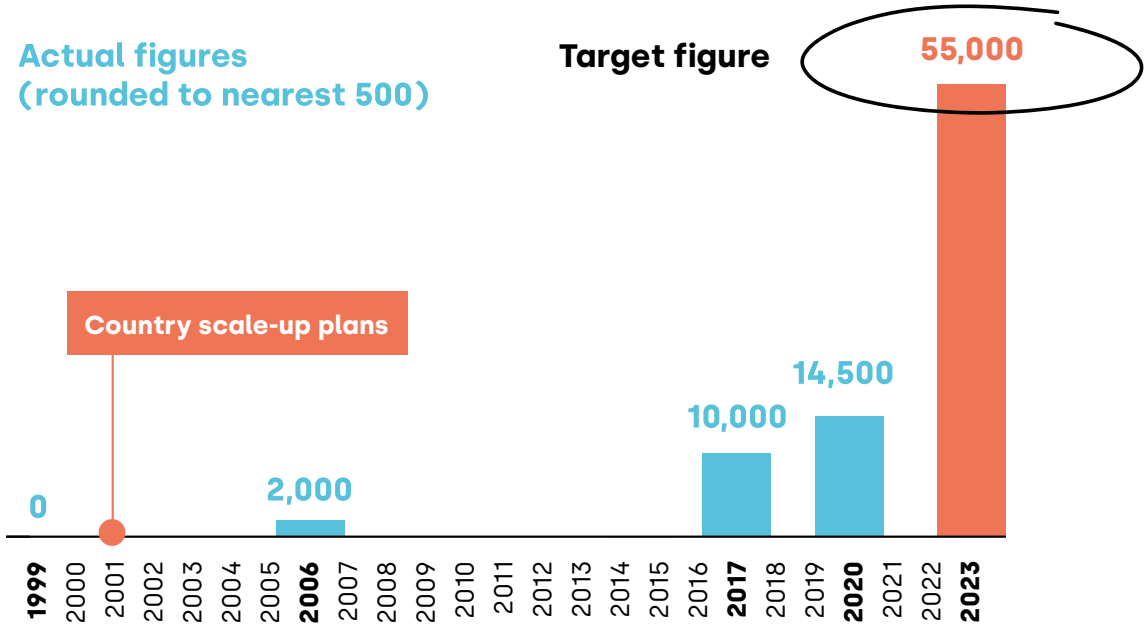
1. **Stakeholder engagement:** Engaging with regional and national governments and raising awareness and understanding of the IPS model, for example through roundtables and lobbying
2. **Integration:** Ensuring that Employment Specialists in new IPS services are integrated into clinical teams; fidelity reviews and training for existing services to encourage integration
3. **Funding:** Exploring different sources of funding. COVID-19 has raised awareness of the importance of mental health, creating an opportunity to promote IPS to funders as part of the solution
4. **Training and quality support:** Ensuring resource for training and quality assurance is built into new IPS services; strengthening connections with the international IPS community
5. **Stigma:** Conducting awareness raising and stigma combatting activities to increase understanding of mental health problems in the general population, and publicising recovery stories from IPS clients
6. **Evidence:** Evaluation and further research to complement data collection and outcome monitoring; building the evidence base and then using national and international networks to disseminate findings

The country plans do not focus on influencing policy, but countries will take opportunities to do this as and when they arise.



> "Bringing different countries together on a common journey can be powerful"

Figure 2. The scale-up of IPS in England (numbers of people accessing IPS)



Where can we expect to get to in two years via these routes to scale?

As explained, each country is at a different point in its scaling journey, and both the approach to scale and the level of scale reached at the end of two years will look different in each place. That being said, in all five countries we are at very early stages of scale. Even in Denmark, where the aim is to increase IPS provision across the whole country, the two year scale-up plan only aims to work with an additional 700–800 people. This is in great contrast to IPS in England, where the aim is now to have 55,000 people accessing IPS by 2023/24.[26]

Figure 2 shows the approximate scale-up of IPS services in England to date in terms of the number of people accessing services, and how this compares to the numbers expected to be reached in the scale-up plans developed for the countries in this project.[27]

As the figure shows, scaling IPS takes a very long time, and the five countries working on this project are only at the beginning of this journey. However, the graph also shows that the rate of increase in the numbers of people reached is not constant. It took almost 20 years for the number of people accessing IPS in England to go from zero to 10,000, but then only three years to go from 10,000 to 14,500, with the expectation that this figure will increase by almost 400% by 2023.

This demonstrates three key principles of scaling IPS:

1. Significant investment is needed at the beginning to build momentum;
2. Reaching large numbers of people takes many years; and
3. Scale starts slowly but then builds quickly

Thus, achieving widespread delivery of IPS across existing sectors and changing the public conversation around mental health and employment will likely take several years. Unlocking new and/or reallocating funding is needed sooner to enable this growth to happen.

Funding and sustainability

Given the variety in service size, the number of services and salaries, the cost of the scale-up plans varies greatly from €150,000 to €8,000,000 across the different countries. All countries are either looking for opportunities or are already in talks with regional and/or national governments to reallocate funding towards the core costs of IPS services. In Croatia, these funds would come from employment budgets, while in Denmark, France and Spain, they come from a mix of employment and health budgets. In the Czech Republic, where two regional governments have already committed to funding IPS services, the funds will come from social services budgets.

In addition to government funds, all countries are very likely to require an additional grant or other philanthropic funding to underpin the surrounding support, training, and quality assurance of their services. Without this wider support, the scale-up of IPS is not sustainable or in some cases not possible at all.

Impact

Whilst numbers are important, these scale-up plans will also have a wider impact than just the number of additional people who have access to an IPS service:

1. **Changing attitudes**: Through raising the profile of IPS and improving links with user groups, these plans will help combat stigma and raise awareness in the professional and wider communities, encouraging the belief that people with SMI are capable of work.

2. **Improving the quality of existing services**: Many of the plans include additional training and fidelity reviews for existing IPS services as well as any new services planned. This will raise the base standard for IPS in each country.

Summary

Scaling IPS across these five different countries in the next two years requires more than funding for additional services. It is also about improving support for current and future services, building the evidence base, and fighting the stigma that persists around mental health.

To do this, each country plans to focus on building strong partnerships with mental health teams, governments, user associations, service users and IPS experts nationally and internationally, and use events and public communications to raise awareness of IPS. The success of the scale-up partly depends on the political and economic contexts, but in doing this work each country is putting itself in the best position to be able to catch waves of change when they come. Through doing this, we believe that we will see widespread IPS in multiple countries in Europe in the next decade.

What does this mean for scaling other evidence-based social interventions?

This project has given us valuable insight into what it takes to scale an evidence-based intervention across multiple countries and contexts.

Bringing different countries together on a common journey can be powerful, but needs strong coordination and investment in relationship building

Working across multiple languages and cultures is difficult and means more time is required to build mutual understanding and strong relationships, particularly when all contact is done remotely. Building in a budget for translation services and occasional in-person meetings with all countries should be considered. Having a project structure with a clear division of labour whereby local experts lead the project in each country and a separate project manager oversees the progress and provides operational expertise, guidance and contacts can also be very effective.

Strategic opportunism is an effective strategy

The success of a scale-up plan is highly dependent on many economic, political and cultural factors. In the context of IPS this includes economic, health and disability and welfare policies, the stigma around mental health, and employer incentives. Whilst many of these factors may be outside of our direct control, spending time researching the local and national contexts and relationship building with key stakeholders means we can have plans ready to engage with funders and seize opportunities when they arise.

International evidence and benchmarks aren't necessarily sufficient – countries need local evidence

Be open to pilots or trials that are owned by the country's government and create the evidence needed to influence policy. Despite the wealth of global evidence behind IPS, we found that evidence at the local level is still needed to persuade governments to invest in the model. Without this, there is a risk that the intervention is viewed as something that works elsewhere but is not applicable to the particular nuances of any given local context.

Scaling an intervention is not just about adding more services, but about building the supporting infrastructure from the beginning to ensure high quality delivery and sustainability

Equally as important as adding new services is building the support infrastructure to provide staff training and quality assurance support. Without this, the growth of high quality services is unsustainable. This can also be a route to scaling in a context where there are no obvious opportunities to add new services, for example if funding resources are scarce. By instead focusing on growing a national network of the existing services, you can increase the intervention's visibility and improve the quality of current services. When there are openings for further funding, the intervention is more likely to be recognised as the model to invest in.

Catalytic funding has a powerful role

There is often very limited capacity outside of frontline delivery teams to build strategic plans or do local engagement, meaning opportunities get missed and effective interventions don't get enough profile. A small amount of catalytic funding can unlock the capacity to do this. In this project, the ESCF funding allowed us to do the necessary research and think about what is needed to scale IPS in each country, who the key stakeholders are, and where the main challenges and opportunities lie. Through this research, the team in Denmark discovered that the scale of IPS in Denmark is already greater than they previously thought, and that there is a strong need for a support institution, while the team in France discovered a need to improve the fidelity of current services.

Having funding from a respected fund such as the ESCF also crucially gave partners a reason to reach out and start conversations with key stakeholders. For example, the Croatian team were able to convene a roundtable with ministers from the central government and connect with IPS experts from the Netherlands who subsequently agreed to help with the pilot. These conversations and discoveries have been invaluable in furthering the IPS agenda in each country we have worked with, and the potential to scale IPS has as a result grown in all countries.

For more information on the scale-up plans in each country, please see contact details below:

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Appendix A
Principles and evidence base for Individual Placement and Support (IPS)[28]

IPS is a person-centred, face-to-face model, defined by eight principles (see Figure 3). These focus on integrating employment support alongside health treatment; providing rapid, personalised job search; tailoring employer engagement to individual aspirations; and offering extended in-work support.

IPS is a well defined variant of the broader category of supported employment interventions, sometimes called "place, train, and retain" in contrast to traditional "train and place" approaches. Traditional models tend to focus on preparing for work, which may include long periods spent in volunteering, training, or sheltered employment. By contrast, supported employment approaches focus on rapid vocational profiling (identifying skills, experience, aspirations, and required work adjustments), job search and brokerage, and then in-work support for both employer and service user.

Multiple systematic evidence reviews have found that supported employment, specifically the IPS model, is significantly more effective at supporting people with severe mental illness into competitive employment than traditional approaches.[29,30] A lack of effective supported employment services has been cited as one of the key barriers for people with mental health problems to find work.[31] This evidence base includes:

1. A review of 15 Randomised Control Trials (RCTs), of which six were from outside the US, showed a 36 percentage point improvement in competitive employment outcomes for participants receiving IPS versus traditional interventions (58.9% achieving a job outcome with IPS versus 23.2% for the control group, averaging across studies). The differential was 30 percentage points for the non-US studies.[32]
2. A more recent review of 19 Randomised Control Trials (RCTs), of which ten were from outside North America, found IPS to be more effective than traditional vocational rehabilitation "regardless of prevailing cultural or economic conditions".[33]
3. Another review of 14 RCTs found evidence that IPS increased the levels of employment, length of job sustainment, and reduced the time taken to get a job.[34]
4. A six-country European trial of IPS found that participants receiving IPS had higher rates of job outcomes (54.5% versus 27.6% for traditional support); worked more hours; and remained in work for longer. It also found an 11 percentage point reduction in hospitalisation rates for people receiving IPS and a four point reduction in time spent in hospital.[35]

IPS has also been successfully applied to support people with first episode psychosis into employment or, if more appropriate, education.[36,37]

Figure 3. Eight principles of IPS

1. It aims to get people into competitive employment – Volunteering or sheltered work are not counted as outcomes.

2. It is open to all those who want to work – With no exclusions based on diagnosis, health condition or benefits claim.

3. It tries to find jobs consistent with people's preferences.

4. It works quickly – Job search starts within four weeks, even if a client has been off work for years.

5. It brings employment specialists into clinical teams – So that employment becomes a core part of mental health treatment and recovery.

6. Employment specialists develop relationships with employers based on a person's work preferences – Not based on who happens to have jobs.

7. It provides ongoing, individualised support for the person and their employer – Helping people to keep their jobs at difficult times.

8. Benefits counselling is included – So no one is made worse off by participating.

Appendix B
Additional context on the employment rate gap in each country[38]

The table below gives the pre-COVID employment rates in each country, split by those with and without limitations in work caused by health conditions or difficulty in a basic activity, as well as the average absence rate due to personal health problems.

	Pre-covid unemployment rate	Employment rate for those with limitation in work caused by health conditions or difficulty in a basic activity	Employment rate for those without limitation in work caused by health conditions or difficulty in a basic activity	Absence from work due to personal health problems
Croatia	6.2%	31.6%	55%	19.4%
Czech Republic	2.0%	34.5%	69.3%	22.5%
Denmark	4.9%	41.4%	80%	50.8%
France	8.1%	59.6%	68%	35.3%
Spain	13.6%	33.%	62%	21.1%

Appendix C
Additional context on mental health and employment support services in each country

	Mental health services	Current IPS provision	Employment services	National policy
Croatia	Mostly delivered in hospitals. Some community services with multi-disciplinary teams. Main referral route through family doctors. Mostly funded through national health insurance.	n/a. Currently no specialised service for people with severe mental illnesses seeking employment.	Occupational and social inclusion programmes run by national employment service and regional professional rehabilitation centres. Publicly funded workplace adjustments, health insurance coverage and in-work support available for some people with disabilities.	Recommends developing and expanding employment opportunities for people with mental health problems.
Czech Republic	Mostly in private outpatient psychiatric clinics and public psychiatric inpatient units. Also community centres across the country providing free health and social care to adults with SMI and other diagnoses. Specialist services usually accessed via self-referral and free at point of use. Health services funded by insurance. Social services funded by Ministry of Labour and Social Affairs and regional governments. Funding based on application every year.	18 NGO IPS providers working in eight out of the 14 Czech Regions. Fidelity of services has not been measured since the initial training. Offered as part of integrated mental health care.	Mostly provided by regional Labour Offices and funded as social services by the state. Only some regions have specialist services for people with disabilities. Also a huge state subsidy for sheltered work. Overall budget is decided by the Ministry for Labour and Social Affairs, but decisions on how to distribute the budget are made regionally.	The Czech National Mental Health Action Plan 2020–2030 aims to implement system change to reduce the unemployment rate of people with mental health problems. The Mental Health Teams Standard in the Czech Republic recommends the role of IPS in supporting people with mental health problems into work. The Psychiatric Care Reform Strategy 2014 aims to develop multi-disciplinary community-based services and has planned to create 100 Mental Health Centres by 2030 and reduce the number of long term beds in psychiatric hospitals by two thirds.

	Mental health services	Current IPS provision	Employment services	National policy
Denmark	Delivered by regional and municipal services and private and third sector organisations in hospitals, outpatient clinics, community mental health teams, Flexible Assertive Community Treatment (FACT) teams, and psychiatric emergency rooms. Main referral route is through GPs. Funded by the state, with decisions made at a regional level. Regional health agreements with municipalities run on a four year basis.	Successful Randomised Control Trial in 2012. IPS now delivered in almost half of municipalities, in partnership with local job centres. Referrals can be made by job centres, vocational services, mental health services, and the individual directly. IPS can also be delivered in outpatient clinics such as early intervention treatment teams, community mental health teams and FACT teams. Fidelity was measured during the pilot, but many teams since have opted out of fidelity reviews due to the high cost; reviews have not been conducted on existing teams for several years. Many job centres have implemented IPS on their own and sought closer collaboration with the regional mental health teams. Some Foundation funding for IPS pilot and private IPS provision.	Delivered by job centres. Individuals have to be able to work and be actively seeking employment unless exempt to access these services. Funded by the state.	A 10-year plan for psychiatry in Denmark is expected this year The Danish Agency for Labour Market and Recruitment (STAR) is currently initiating a project where IPS is implemented in three additional municipalities.
France	Private services for less severe problems which don't require a multi-disciplinary team. Public healthcare institution services mainly focus on the treatment of more severe and persistent problems requiring the intervention of a multi-disciplinary team. Mainly funded by Regional Health Agencies.	A minority of supported employment services in France refer to the IPS model, to varying degrees, and the large majority do not have fidelity reviews. A few 'IPS inspired job-coaching services' which are open to people who have mental health problems but aren't recognized as disabled workers. These services are not integrated with mental health services.	Coordinated by the job centres which provide a single point of contact for registering, counselling, training, placing and paying benefits to job seekers. Some specific support for people with disabilities. Funded by social insurance, employers directly, the job centre, regional funding, and local bodies such as department councils. Sheltered workshops are still heavily funded by the state and RHAs.	Psychiatry and Mental Health Plan 2018–2023. 2016 Labour Law recommends supported employment as good practice but does not mention IPS.

	Mental health services	Current IPS provision	Employment services	National policy
Spain	Hospital and community treatment. All services free at point of use. Accessed in primary healthcare settings as well as specialised outpatient settings. Publicly funded via the National Health System.	IPS has existed in Spain since a pilot was run in Catalonia in 2013. Services are more or less integrated into mental health services, although this varies. Still mainly exists in Catalonia, but some organisations in Madrid and Murcia are trained to implement IPS. Andalusia and Las Canarias have also shifted their practice to be more similar to IPS in recent years.	Employment support services, including sheltered work initiatives and job placements for specific groups of people, are delivered by NGOs and public organisations. National Employment System is made up of the State Public Employment Service. People with disabilities must receive a certificate accredited by the local authority to access support. Employers can receive financial support from the National Institute of Social Security to make adaptations for workers with disabilities. Sheltered workshops receive benefits from the government.	Governance of healthcare transferred to local authorities and very regionalised. Supported employment not currently legislated at a national level in Spain, but the Spanish Mental Health Strategy 2009–2013 states that supported employment should be included in recovery and supports IPS at a national level as an effective, evidence-based practice. Some local authority mental health strategic plans outline employment as recovery as a strategic issue, and specifically focus on supported employment and competitive job acquisition. The Spanish Employment Activation Strategy 2014-16 set targets to be attained by public employment services aimed at improving the employability of youth and other groups particularly affected by unemployment.

Appendix D
Summary table of country scale-up plans

	Area scaling across	Main activity	Service size	Funding sources
Croatia	One region.	Pilot service.	Two Employment Specialists.	Main: Central government – Employment, Ministry for Labour and Social Services. Secondary: Philanthropic funding.
Czech Republic	Two regions.	Establishing two new services.	Service 1: Three Employment Specialists. Service 2: Four Employment Specialists.	Main: Regional governments' social services budget. Secondary: Philanthropic funding.
Denmark	Whole country.	Creation of Danish IPS Learning Community.	One regional implementation consultant per region. Expectation of 30 additional Employment Specialists by Year two.	Main: Co-funding model between regions. Secondary: Potentially central government investment and/or philanthropic funding.
France	Whole country.	Disseminating IPS model via Supported Employment platform and looking to introduce IPS services to the Medico-Psychological Community Centres which belong to the Public Mental Health services funded by Health Care Insurance.		Regional Health Agencies and money from employers' contributions/penalties.
Spain	Four regions.	Creation of national network/learning community. Additional support for existing services & creation of two new services.	11 Employment Specialists in total.	Main: Local or regional government. Secondary: Philanthropic funding.

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Endnotes

1 OECD (2012), Sick on the Job? Myths and Realities about Mental Health and Work, Mental Health and Work, OECD Publishing. http://dx.doi.org/10.1787/9789264124523-en

2 IES Briefing, Labour Market Statistics, August 2021, https://www.employment-studies.co.uk/system/files/resources/files/IES%20briefing%20-%20Labour%20Market%20Statistics%20August%202021.pdf

3 Rinaldi, M., Perkins, R., Glynn, E., Montibeller, T., Clenaghan, M., & Rutherford, J. (2008). Individual placement and support: From research to practice. **Advances in Psychiatric Treatment**, 14(1), 50-60. doi:10.1192/apt.bp.107.003509

4 In the UK, 'severe mental illness' or 'SMI' refers to psychological problems that are often so debilitating that the person's ability to engage in functional and occupational activities is severely impaired, such as schizophrenia and bipolar disorder. See https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing for more information.

5 Every IPS client is assigned an Employment Specialist, whose job it is to work with the client's mental health team and with potential and/or current employers to support the client to find a suitable job which aligns to their preferences and needs.

6 Becker, D. R., & Bond, G. R. (2020, January 30). Commentary on Special Issue on Individual Placement and Support (IPS) **International, Psychiatric Rehabilitation Journal.** Advance online publication, http://dx.doi.org/10.1037/prj0000402

7 https://www.centreformentalhealth.org.uk/sites/default/files/the_evidence_for_ips.pdf

8 Burns, Tom et al. "Individual Placement and Support in Europe: the EQOLISE trial." **International Review of Psychiatry** (Abingdon, England) vol. 20,6 (2008): 498-502, https://pubmed.ncbi.nlm.nih.gov/19085404/

9 More details on the evidence base behind IPS, and on the IPS model itself can be found in Appendix A of this report.

10 https://www.socialfinance.org.uk/resources/publications/changing-lives-changing-systems-building-routes-scale

11 Various studies. See for example Gühne, U, et al (2021), Employment status and desire for work in severe mental illness: results from an observational, cross-sectional study, **Social Psychiatry and Psychiatric Epidemiology** (2021) 56:1657–1667 https://doi.org/10.1007/s00127-021-02088-8, Marwaha S, Johnson S (2005), Views and experiences of employment among people with psychosis: a qualitative descriptive study. Int J Soc Psychiatry;51(4):302-16. doi: 10.1177/0020764005057386, or Mueser KT, Salyers MP, Mueser PR (2001), A prospective analysis of work in schizophrenia. **Schizophr Bull**;27(2):281-96. doi: 10.1093/oxfordjournals.schbul.a006874

12 Marwaha S, Johnson S (2004) Schizophrenia and employment: A review, **Social Psychiatry and Psychiatric Epidemiology** 39:337–349. https://doi.org/10.1007/s00127-004-0762-4

13 Parabiaghi A, Bonetto C, Ruggeri M, Lasalvia M (2006) Severe and persistent mental illness: a useful definition for prioritizing community-based mental health service interventions. **Soc Psychiatry Psychiatr Epidemiol** 41:457–463. https://doi.org/10.1007/s00127-006-0048-0

14 NHS Digital (2020), Measures from the Adult Social Care Outcomes Framework England 2019-20, https://files.digital.nhs.uk/6F/78B873/meas-from-asc-of-eng-1920-ASCOF-report.pdf

15 Mental Health Foundation (2007), The Fundamental Facts, https://www.oecd.org/els/mental-health-and-work-9789264124523-en.htm; OECD (2012), Sick on the Job? Myths and realities about mental health and work, Paris, OECD Publishing

16 https://www.health.org.uk/sites/default/files/2021-04/2021%20-%20Unemployment%20and%20mental%20health.pdf

17 Bond GR, Drake RE, Becker DR. An update on randomized controlled trials of evidence-based supported employment. **Psychiatr Rehabil J.** 2008 Spring;31(4):280-90. doi: 10.2975/31.4.2008.280.290. PMID: 18407876.

18 Centre for Mental Health UK analysis, referenced in Notes to Editors at: https://www.gov.uk/government/news/pm-improve-mental-health-treatment-to-get-thousands-more-back-to-work

19 DWP and DHSC (2017). Improving Lives The Future of Work, Health and Disability, https://www.gov.uk/government/publications/improving-lives-the-future-of-work-health-and-disability

20 The Behavioural Insights Team (2020), Individual Placement and Support: A Social Impact Bond Model Evaluation Report, https://s3.eu-west-2.amazonaws.com/golab.prod/documents/Social_Impact_Bond_IPS_Research_Report_Final.pdf, p.29

21 Becker, D. R., & Bond, G. R. (2020, January 30). Commentary on Special Issue on Individual Placement and Support (IPS) International. **Psychiatric Rehabilitation Journal**. Advance online publication, http://dx.doi.org/10.1037/prj0000402

22 Ibid.

23 These are key 'strategic levers' to scale, taken from the **Routes to Scale** framework: https://www.socialfinance.org.uk/resources/publications/changing-lives-changing-systems-building-routes-scale

24 Becker, D. R., & Bond, G. R. (2020, January 30). Commentary on Special Issue on Individual Placement and Support (IPS) International. **Psychiatric Rehabilitation Journal**. Advance online publication, https://doi.apa.org/doiLanding?doi=10.1037/prj0000402

25 Bond GR, Lockett H, van Weeghel J (2020). International growth of individual placement and support. **Epidemiology and Psychiatric Sciences** 29, e183, 1–3. https://doi.org/10.1017/S2045796020000955

26 NHS Long Term Plan, https://www.longtermplan.nhs.uk/online-version/appendix/health-and-employment/

27 Figures taken from following sources: https://waamh.org.au/assets/documents/ips/rachel-perkins----ips-in-the-uk.ppt; IPS Grow Impact Report 2021, https://s38158.pcdn.co/wp-content/uploads/IPS-Grow-Impact-Report-2021.pdf; NHS England, https://www.england.nhs.uk/mental-health/case-studies/individual-placement-and-support-ips-for-people-with-severe-mental-illness/

28 This section draws significantly from "Commissioning guidance: Mental health and employment services", IPS Grow (June 2018): https://s38158.pcdn.co/wp-content/uploads/1.2-Comm_Guid_Supported_Empl-1-1-1.pdf

29 Supported employment for adults with severe mental illness (Review). Kinoshita et al, **Cochrane Library** (2013)

30 Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US. Gary R. Bond, Robert E. Drake, Deborah R. Becker. World Psychiatry 2012:11:32-39

31 Boardman J, Rinaldi M. Difficulties in implementing supported employment for people with severe mental health problems. **Br J Psychiatry** 2013; 203: 247–249

32 Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US. Gary R. Bond, Robert E. Drake, Deborah R. Becker. **World Psychiatry** 2012:11:32-39

33 Modini M, Tan L, Brinchmann B, Wang M-J, Killackey E, Glozier N. et al Supported employment for people with severe mental illness: systematic review and meta-analysis of the international evidence. **Br J Psychiatry** 2016; 209: 14-22

34 Supported employment for adults with severe mental illness (Review). Konishita et al. **Cochrane Database of Systematic Reviews** 2013, Issue 9.

35 "Getting Back to Work with psychosis: The European experience" – presentation by Professor Tom Burns, based on results of EQOLISE trial

36 Individual Placement and Support for Individuals with Recent-Onset Schizophrenia: Integrating Supported Education and Supported Employment. Nuechterlein et al. **Psychiatric Rehabilitation Journal** 2008. Volume 31. No. 4. 340-349

37 Killackey E, Jackson HJ, McGorry PD. Vocational intervention in first episode psychosis: individual placement and support v. treatment as usual. **Br J Psychiatry**. 2008; 193(2): 114-20

38 OECD/European Union (2018), Health at a Glance: Europe 2018: State of Health in the EU Cycle, OECD Publishing, Paris/European Union, Brussels, https://doi.org/10.1787/health_glance_eur-2018-en.

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