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Implementation study of 'Take Charge', a prototype Individual Placement and Support adaptation for young benefit recipients

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Disclaimer

The views, opinions, findings, and recommendations expressed in this report are strictly those of the authors. They do not necessarily reflect the views of the Ministry of Social Development, other organisations involved in the study, or people involved in the peer review process. Any errors or omissions are our own.

Conflicts of interest statement

The authors are all employees of the Ministry of Social Development, which funded the prototype.

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Glossary of Māori language terms

For the benefit of international readers, the Māori language (Te Reo Māori) is an official language of Aotearoa New Zealand, and Māori terms are commonly used in New Zealand to describe Māori concepts and as names of organisations and programmes.

This glossary provides an explanation of some key Māori terms and Māori names used in this report. The source used for many of the definitions is Te Aka Māori-English English-Māori Dictionary online: https://maoridictionary.co.nz/. Translations given are those most relevant to the use within this paper.

Kaumātua	Māori elders
Kaupapa Māori	A Māori approach, incorporating the knowledge, skills, attitudes and values of Māori society
Karakia	Prayer, grace, blessing
Mihi mihi	Māori introductory speech or greeting
Te Whare Tapa Whā	A holistic Māori model of wellbeing used in kaupapa Māori and mainstream services and sectors.
Whakapapa	Lineage, decent, where you come from
Whakawhanaungatanga	Process of establishing relationships, relating well to others
Whānau	Extended family, family group

Use of language

In bringing together material from different sources, there is sometimes a need to accommodate different world views expressed through language (Te Pou, 2013).

For example, in this report we use the phrase 'people with serious mental illness' when we need to be clear about the people who Individual Placement and Support is usually intended to help.

We also use the phrase 'people with mental health conditions' and the term 'disorder' when we need to use language that is consistent with that used in other studies we discuss, to accurately report the results of those studies and to link our results to the wider research base.

But we recognise that people are people first, and terms like these do not define their identities (Becker & Drake, 2003, p viii). We are also aware that using such terms can increase stigma (Kvalsvig, 2018). It is not our intention to cause offence or harm through the use of terminology in this report.

Executive summary

Individual Placement and Support (IPS) is a well-specified, integrated approach to providing employment support that has been shown to be more effective than alternative approaches in helping people with serious mental illness get into work.

IPS usually involves 'Employment Consultants' co-locating and working very closely with a publicly-funded mental health or addiction treatment team to provide integrated mental health treatment and employment supports to clients. Referrals usually come from the mental health or addiction treatment team.

Internationally, there is little evidence on adaptations to IPS to effectively tailor the approach for young benefit recipients who present with mild or moderate mental health problems and/or substance abuse issues.

In 2017, funding was made available for the Ministry of Social Development (MSD) to trial an adaptation for this target group. The 'Take Charge' adaptation was co-designed by MSD and Odyssey House Trust in Christchurch, and delivered by the Community Youth Mental Health Service in Christchurch.

This report draws together findings from the first stage of a study of Take Charge. This stage involved the development of a small prototype of the service in 2018, and an associated implementation study. The intention was to determine whether there was sufficient promise to proceed further, and if so, whether modifications were needed.

Take Charge

The design of the Take Charge prototype was informed by IPS practices and principles. Some IPS practices and principles were intended to be applied without modification. These were:

- **focus on competitive employment** – the primary goal is employment in mainstream competitive jobs that are either part-time or full-time
- **attention to client preferences** – the job search is consistent with an individual's job preferences
- **systematic job development** – Employment Consultants develop relationships with employers and seek work opportunities for their clients based on a person's stated work preferences
- **work incentives planning** – benefits counselling (including advice on how working will affect benefits) supports the person to transition from benefit to work
- **rapid job search for competitive jobs** – people are helped to look for jobs soon after beginning employment support.

In other parts of the design, the way IPS principles and practices were applied was tailored to the target group, or the IPS approach was adapted in a way intended to be congruent with fidelity to IPS principles and practices.

The way the IPS principle of **integration of mental health and employment services** was applied involved creating a new service that allowed young benefit recipients, many of whom were not expected to meet the threshold for publicly-funded mental health or addiction treatment, to access mental health care integrated with additional support for employment.

The mental health care of the participants involved a 'Take Charge Co-ordinator' providing pastoral care (mentoring, counselling, social support). The Take Charge Co-ordinator also helped young people access other mental health and addiction services provided by GPs,

specialist teams, and other organisations where these were needed. Mental health care was delivered alongside employment support provided by an 'Employment Consultant'. Referrals to Take Charge came from the benefit agency – Work and Income – rather than from a mental health treatment team.

IPS fidelity-congruent adaptations included the addition of group-based motivational workshops at entry to the programme focussed on skills and strategies that could help participants meet their employment goals, a flexi-fund of up to $800 per participant for direct purchasing of services or products that would support them getting or keeping a job, and a 'Positive Youth Development' approach to working with the young people in the service. This approach focusses on supporting young people to develop a sense of competence, usefulness, belonging and empowerment.

In a fidelity non-congruent departure from IPS practices, support was time limited given the short duration of the funding for the prototype.

The implementation study approach

Implementation study activities included an independent formative evaluation of the prototype, and collection of de-identified monitoring data and questionnaires. A fidelity review was also conducted which assessed the level of adherence to the evidence-based practices and principles of IPS.

The formative evaluation involved interviews with 26 of the 44 young people who participated in the prototype (31 participants were approached to be interviewed and 84 percent consented). It also involved interviews with three whānau or family members supporting the young people, and 12 interviews with staff involved in the design and delivery of Take Charge. The formative evaluation also drew on workshop observations and document review. It was informed by a review of research evidence on best practice for working with young people with mild or moderate mental ill-health or substance use issues, and best practice for supporting the transition of young people into employment.

The implementation study was not intended to assess the degree to which participant outcomes reflected the impact of the service.

The Take Charge participants

The prototype service was offered to young benefit recipients aged 18-19 years living in Christchurch. The target group included those receiving a benefit due to a health condition with a medical certificate (usually provided by a GP) indicating they had a stress-related disorder, depression, another psychological or psychiatric condition and/or an alcohol or drug disorder. Participants who had a serious mental illness (bipolar disorder or schizophrenia) or significant co-occurring physical health problems or disabilities were not eligible. Participation was voluntary.

The 44 young people who consented to join the study entered Take Charge between May and September 2018. All were receiving a Jobseeker Support benefit with a medical deferral. One quarter of the participants were Māori. Most (41) were under the care of their GP. Only three were receiving care from a District Health Board mental health treatment team at the time they entered the service.

Monitoring data suggests the rate of retaining participants in the service was high (89 percent of participants were still engaged at three months), although there were considerable gaps in contact with the service for some participants.

Formative evaluation findings

Based on the way interviewed participants described the support they received, the independent evaluators assessed the quality of the pastoral support to be high and in keeping with internationally-accepted best practice for working with this group. Many interviewees expressed genuine surprise at the level and quality of pastoral support they received.

For some, the pastoral support was transformative in terms of building their confidence. Many participants reported that the supportive environment of Take Charge helped them see a way towards managing their mental health and embarking on an employment search.

When interviewed, Māori participants responded positively when asked about inclusivity and respect in relation to their culture. None reported feeling discouraged from joining or remaining in Take Charge due to a lack of cultural responsiveness.

An important challenge reported by the Take Charge team in working with these young people was the apparent impulsivity and changeability across a range of psychological states and behaviours (eg feelings of being able to cope, then not cope; being in work or relationships, then not; being in and out of contact with the Take Charge team).

In the interviews with the whānau or caregivers of three of the participants, most reported finding Take Charge very supportive. There is, however, still some way to go in building connections with whānau, and opportunities should be sought to further develop contact with and support for whānau throughout the process and practice of the programme. In best practice this is broadly understood to include connection with 'significant adults' trusted by the young person.

Employment support was offered taking a 'high challenge/high support' approach. This is an important element of best practice in working with young people, provided the level of support meets the level of the challenge experienced. Some of the interviewed participants responded well to this approach, while others found it too difficult, given their current levels of mental health.

All those interviewed were supportive of the group workshops as part of the service. Many of the young people interviewed reported that they had initially felt anxious about being in a group setting. However, once they took the first step to attend and discovered they could manage that, they grew in confidence.

As a result of the pastoral care and knowledge gained in the workshops, participants interviewed reported that they grew in their understanding of their own mental health and, to a certain extent, developed their capacity to manage this. Some learned and practised tools to manage situations that would have been difficult for them in the past.

The way participants were initially recruited to the programme from Work and Income was not in keeping with best practice. Being "cold called" created anxiety for many interviewees. The recruitment process was amended over the course of the prototype with a move away from cold calling towards case managers promoting Take Charge as part of routine face-to-face and phone-based case management with eligible clients. This approach was seen as more successful, and could be further developed to better align with the best practice principle that 'any door is the right door' to increase the likelihood that Take Charge is a good fit with where a young person is at.

Fidelity to IPS practices and principles

Independent reviewers assessed the Take Charge prototype as not having sufficient fidelity to IPS practices and principles to be considered IPS employment support. This was

not unexpected given the short period of operation, the adaptations to IPS made by the prototype, and the small size of the Take Charge team.

The reviewers commended the combined efforts, the 'whatever it takes' attitude and commitment of the Take Charge team, and the collaborative approach established with Work and Income. The prototype had been developed quickly, with limited resources and limited IPS expertise.

Key recommendations for immediate focus that would lift IPS fidelity to 'Fair' related to:

- improving integration of employment support provided by the Employment Consultant with mental health care provided by the Take Charge Co-ordinator
- considering increasing the size of the Take Charge team
- clarifying and strengthening an employment supervisor role within the team
- accessing IPS training and technical support
- Employment Consultants focussing more on job development activities.

Outcomes

While the prototype stage of the study was not intended to measure the impact of Take Charge on participants' outcomes, some monitoring information on outcomes was gathered.

At the end of January 2019, of the 25 participants able to be followed for six months from enrolment, 16 (64 percent) had commenced employment within the six month window.

Over the course of the prototype, 10 participants went on to receive care from District Health Board services. This primarily involved referrals to psychiatric emergency services but there were also referrals to an anxiety disorders clinic, and requests by the GP for psychiatric review. The triggers for referrals to psychiatric emergency services were understood to be mainly related to relationships, loss and grief, and were seen to reflect the existing high level of changeability in mental health and ability to cope in the group observed by the Take Charge team.

Study limitations

Because there was no control group, it is not possible to say what might have occurred for the participants in the absence of Take Charge, and whether and to what degree the service contributed to the outcomes observed. In addition, it was not possible to interview those who did not wish to take part in the programme, and only a very small number of family and whānau members were able to be interviewed. Findings and recommendations should be read in this light.

Recommendations

It is recommended that programme partners continue to develop a valued service that fills an important service gap. Drawing on the different evaluation strands, recommendations that can inform further development of the service include the following:

- **Strengthen best practice guidance for cultural responsiveness.** Further research on IPS delivery in the cultural context of Aotearoa New Zealand would be a useful addition to the evidence base.
- **Involve families and whānau or other significant support people where possible.** To be culturally responsive, and to align with best practice when working with young people and emerging IPS research, it is important to engage often with family and whānau members.

- **Increase staffing and clarify staff roles.** Recommendations for lifting IPS fidelity include increasing the size of the Take Charge team to include two consultants, and a supervisor who has the role of improving oversight, up skilling the team in the IPS approach, and providing mentoring.
- **Support young people with education and training where this provides a pathway for them to achieve their employment goals, and recognise participation in education or training as a successful outcome.** Although good practice in this respect was observed, support for education and training was not an explicit part of the Take Charge design. Recognising education or training as a successful outcome would accord with best practice in relation to the developmental needs of the young people participating in the service.
- **Build staff skills and training, and build understanding of how to support young people to broaden their employment horizons and expectations.** In the prototype, the Take Charge Co-ordinator was not trained in employment support, and the Employment Consultant was not trained in mental health support.
- **Further develop integration with mental health supports and referral pathways.** A useful modification would be to enable young people already receiving mental health services from the Community Youth Mental Health Service team to be referred to the Employment Consultant. Another would be to explore the feasibility of additional referral pathways that strengthen connections with primary care, and with other local mental health services.
- **Improve the Work and Income referral process.** Reliance on work capacity and medical information recorded on the medical certificate to identify a group with 'mild-to-moderate' needs who could benefit from Take Charge was problematic. Reducing reliance on medical certificates in recruitment, and continuing the approach of recruiting as part of face-to-face and phone-based case management is recommended. Any move to open up opportunities for more intensive, one-on-one case management relationships between Work and Income case managers and clients, and ongoing training in mental health for case managers, is likely to improve understanding of young people's needs and work interests and capabilities, and improve the suitability of referrals.
- **Expand access to all young benefit recipients wanting to work who want the supports Take Charge offers, regardless of benefit type and reason for claim.** Many people with mental health conditions claiming welfare benefits that are not health-related could benefit from a service that combines mental health and employment supports.
- **Continue to monitor referrals to psychiatric emergency services for severe psychological distress and assess whether further modifications to Take Charge are required.** The service encountered greater levels of psychological distress among some participants than expected, and while modifications that improve referral pathways are expected to improve the fit of the needs of participants to the services Take Charge can offer, it will be important to continue to monitor severe psychological distress and assess the need for further service modifications.
- **Consider policy and Work and Income supports for a 'graded' transition to work that might involve part-time work as a first step.** Half of participants who entered employment within six months went into part-time work. Emerging evidence on successful return-to-work programmes for people with common mental health problems suggests that providing supports for a graded return to work involving part-time employment may be associated with greater programme effectiveness.
- **Further develop the workshops and document the model.** The group setting of the workshops was beneficial and should continue, with attention to the mix of each group. It would be useful to ensure all workshop content is evidence-based, including in relation to cultural responsiveness.

- **Recognise and address high administrative load.** The administrative load of Take Charge was heavy, partly due in part, to the changeability of the participants in their needs and their engagement.
- **Embed IPS technical assistance and independent fidelity reviews.** Findings from this evaluation highlight the important role that independent fidelity reviews provided by individuals experienced in IPS can play in providing information that can be used to improve the quality of IPS implementation. Technical assistance would be a useful means of ensuring that Take Charge delivers IPS, with adaptations.
- **Acknowledge the complexity of participants' lives and structural factors.** This includes family and whānau dynamics (both supportive and otherwise) and participants' history of trauma, as well as employment context and culture.

Next steps

Based on indications of success from the prototype, the Take Charge initiative will continue to be developed with modifications that respond to the evaluation findings, and strengthen fidelity to IPS practices and principles while preserving and enhancing the group-based adaptations that appear to have been successful.

The next stage of the study will include further fidelity reviews to assess whether, following modification, Take Charge delivers IPS, continued monitoring and gathering of implementation learnings, and an impact evaluation. A Māori-centred study is also planned, with the aim of helping funders, IPS providers, fidelity reviewers and IPS teams attend to cultural responsiveness.

1. Introduction

In the New Zealand Government's 2017 Budget, funding was provided for the Ministry of Social Development (MSD) to purchase over four years up to 500 Individual Placement and Support (IPS) places adapted for young benefit recipients. The adaptation was co-designed by MSD and Odyssey House Trust in Christchurch. It was delivered by the Community Youth Mental Health Service in Christchurch.

IPS is a well-specified approach to providing employment support that has been shown to be more effective than other approaches in helping people with serious mental illness (eg schizophrenia, bipolar disorder, and co-occurring mental and substance use disorders) into work in a range of countries (Modini et al., 2016). IPS services have been operating in Aotearoa New Zealand for some years but are not available in most District Health Boards (DHBs). Existing services are in most cases situated within DHB mental health treatment teams (Lockett, Waghorn, & Kydd, 2018b).

The 'Take Charge' initiative was intended to test an adaptation of IPS tailored to young benefit recipients expected to have mild or moderate mental health problems, most of whom would not be expected to meet the threshold for DHB mental health treatment services.

Report outline

This report draws together findings from the first stage of a study of the Take Charge initiative that is underway. This stage involved development and evaluation of a small prototype of the service to assess whether Take Charge should proceed further, and if so whether modifications were needed. It is important to emphasise that the prototype stage and the associated implementation study were not set up to assess the degree to which employment outcomes observed for participants reflected the impact of Take Charge, or the extent to which they were sustained. These are tasks for a later stage.

The report begins with background information on IPS, the origins of the Take Charge initiative, and the implementation study design (Section 2). We then describe the Take Charge prototype, and the way that it adapted IPS (Section 3). Sections 4-8 bring together the findings, addressing the following questions.

- **Participants, retention, and activities** (Section 4): Who participated in the prototype? What was the rate of retention in the service and why did people leave? What were participant levels of participation in Take Charge activities?
- **Formative evaluation findings** (Section 5): How did the young people who participated experience Take Charge? How did providers of the service and families and whānau experience the service? Compared to best practice for young people with mild or moderate mental health conditions and for supporting young people in the transition to employment, was the mix of activities appropriate? Were there any unintended impacts? How were contextual factors influencing the initiative?
- **Cultural acceptability and responsiveness for Māori** (Section 6): How did Māori participants experience Take Charge? Did insights gathered in the evaluation suggest a need for changes to improve cultural acceptability and responsiveness?
- **Fidelity to IPS principles and practices** (Section 7): What was the level of fidelity to IPS principles and practices? What changes were recommended?
- **Monitoring data on outcomes** (Section 8): What proportion of participants moved into employment and education in the short-term? How many were referred to other mental health services?

Section 9 outlines limitations of the prototype evaluation. Section 10 presents our discussion and recommendations, including modifications that could improve Take Charge. Section 11 concludes and sets out next steps for the study.

2. Background

Young people, benefits, mental health and work

A range of factors is associated with poor mental health. These factors include joblessness and low paid work, poverty, past experience of trauma, social isolation, and, for Māori, the legacy of colonisation, deprivation and cultural alienation (Cunningham et al., 2018; He Ara Oranga, 2018). Young people and adults who are Māori or members of Pacific or other minority ethnic groups report higher levels of ethnic discrimination and racism, and these experiences are also associated with poor mental health (Cormack, Stanley, & Harris, 2018; Crengle, Robinson, Ameratunga, Clark, & Raphael, 2012).

In common with other OECD countries, Aotearoa New Zealand has a high prevalence of poor mental health among benefit recipients (OECD, 2018). Surveyed rates are likely to underestimate the true prevalence of conditions, missing those that are undiagnosed or for which help has not been sought (Cunningham et al., 2018). Māori and Pacific peoples have higher rates of mood and anxiety disorders (Cunningham et al., 2018), and Māori, and to a lesser extent Pacific people, are over-represented among those supported by health-related benefits.[1]

The causal relationships between mental health, joblessness and benefit receipt are complex. Poor mental health places young people at higher risk of educational underachievement and difficulties in transitioning from school and post-school education and training to work, and it appears that joblessness and benefit receipt can in turn contribute to poor mental health. But while employment can have a positive effect on recovery, poor quality jobs, or jobs and work environments that do not offer modifications that acknowledge a person's health condition or disability, can be detrimental (Leach et al., 2011; OECD, 2014).

A series of reports has highlighted the need for early intervention to prevent long-term joblessness and improve mental health (He Ara Oranga, 2018; OECD, 2015, 2018; Orygen Youth Health Research Centre, 2014). The time lag from the onset of a mental health problem, which most often occurs in childhood or adolescence, to its first treatment is typically 10-15 years (OECD, 2018). Early, non-stigmatising supports for young people are critical (OECD, 2018; Orygen Youth Health Research Centre, 2014).

Providing integrated and individualised health and employment services to young benefit recipients with mild or moderate mental health problems at high risk of ongoing difficulties with mental health, and difficulties with successfully transitioning to working life, appears to be a useful part of the way forward (OECD, 2015; Orygen Youth Health Research Centre, 2014; Sveinsdottir et al., 2016).

If culturally accessible and appropriate, such an approach aligns well with the vision for improved community-based support and primary mental health services for youth set out in the recent report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga, 2018, p92) and the OECD's country report on mental health and work (OECD, 2018).

[1] Unpublished rates based on research data, derived by MSD.

The Individual Placement and Support approach

Individual Placement and Support (IPS) is an internationally used, evidence-based integrated approach to employment support for people who have serious mental illness. The approach is based on eight principles and practices:

- **integration of mental health and employment services:** Employment Consultants and clinical teams work in an integrated way and are located together
- **focus on competitive employment:** the primary goal is employment in mainstream competitive jobs, paying minimum wage or above, either part-time or full-time
- **eligibility based on client choice:** 'zero exclusions' apply from referral through to IPS delivery – everyone served by the clinical team who is interested in working is eligible for employment support regardless of factors such as job-readiness, substance abuse, mental health symptoms, history of violent behaviour, cognitive impairment, legal system involvement and personal presentation
- **attention to client preferences:** job search is consistent with the individual's preferences
- **rapid job search:** people are helped to look for jobs soon after entering the programme instead of being required to first participate in training, intermediate work experience, vocational assessments, or sheltered employment
- **systematic job development:** Employment Consultants develop relationships with employers and seek out work opportunities based upon a person's work preferences
- **individualised job supports:** support is time-unlimited and individualised to both the employer and the employee. Some people try out several jobs before finding employment
- **work incentives planning:** benefits counselling, including advice on how working will affect benefits, supports the person through the transition from benefits to work (Becker, Swanson, Bond, & Merrens, 2011; G. R. Bond, Drake, & Becker, 2012).

Existing evidence

In systematic reviews and meta-analyses (eg. Modini et al., 2016; Lockett, Waghorn, Kydd, & Chant, 2016; Marshall et al., 2014; Bond et al., 2012), including a Cochrane review (Kinoshita et al., 2013b), IPS has consistently been shown to be more effective than the best locally available alternative approaches in helping people into work, with evidence for higher proportions of participants commencing competitive employment, more hours worked, more weeks worked per year, and higher wages.

A systematic review and meta-analysis of 17 randomised controlled trials (RCTs) in 10 countries found IPS more than doubled the rate at which participants gained employment (the pooled risk ratio was 2.40, 95 percent CI 1.99–2.90) (Modini et al., 2016). Routine programmes (implemented without an RCT) lose little effectiveness when compared to results from RCTs, although the proportion of participants commencing employment is lower since the Global Financial Crisis in both RCTs and routine programmes (Richter & Hoffmann, 2018).

A small number of studies show the approach is effective for young adults with serious mental illness (Bond, Drake, & Campbell, 2016; Rinaldi et al., 2010). A modification that can be made in tailoring the programme to young people, whose educational attainment and career aspirations may have been limited by mental ill-health, is incorporating support

for educational goals alongside competitive employment (Bond et al., 2016; Ellison et al., 2015), and adding peer workers and support with career development (Ellison et al., 2015). While this has received little research attention, emerging evidence is encouraging (Higgins et al., 2019; Maru, Rogers, Hutchinson, & Shappell, 2018).

Evidence on whether additional components (eg cognitive behavioural therapy and psychosocial skills training) can improve programme effectiveness is still emerging (Dewa, Loong, Trojanowski, & Bonato, 2018). IPS is resource intensive, and while there has been some limited research on adaptation to reduce cost and increase the numbers of clients able to be served, (eg through time limited support (Burns et al., 2015)), more research is needed.

Based on the current literature, adaptation of IPS to incorporate group-based components for young people has been limited (Ellison et al., 2015). There is some evidence to support group-based components as an area for development:

- the delivery of cognitive behavioural therapy in group settings has been shown to be effective (Whitfield, 2010)
- group workshops aimed at enhancing job search skills for unemployed adults that also incorporate mental health promotion elements (eg enhancing participants' sense of control, increasing their confidence, and fortifying resistance and persistence in the face of setbacks and barriers) have been shown to be effective in increasing employment and improving mental health (Reynolds, Barry, & Gabhainn, 2012).

Other evidence gaps exist. There is little evidence on the effectiveness of IPS for different ethnic groups and for indigenous people (Closing the Gap Clearinghouse, 2014; Marshall et al., 2014;). Few studies have examined non-vocational outcomes including mental state, personal recovery, empowerment, quality of life and cost effectiveness (Frederick & VanderWeele, 2019; Kinoshita et al., 2013 (Bejerholm, Larsson, & Johanson, 2017; Kinoshita et al., 2013; Marshall et al., 2014). In a recent meta-analysis, there was some evidence that IPS may improve quality of life and perhaps global functioning, but more research with larger sample sizes is needed to confirm this (Frederick & VanderWeele, 2019). In a six-country European RCT, IPS produced better outcomes than alternative vocational services at lower cost overall to the health and social care systems (Knapp et al., 2013). Different social security and benefit systems, mental health service systems, and employment and regulatory contexts may moderate the outcomes of IPS and research is needed to determine what adaptations are needed in different contexts (Bond et al., 2012; Lockett, Waghorn, & Kydd, 2018a).

There is a lack of evidence on IPS adaptations for young benefit recipients. A Norwegian RCT of an adaptation for young benefit recipients with high health and social needs is underway (Sveinsdottir et al., 2016). While yet to deliver findings on effectiveness, initial results from this study highlight the substantial challenges facing participants as a result of adverse social experiences. Two-thirds reported having been bullied, and participants emphasised relationship problems as the main causal factor for their illness (Sveinsdottir, Eriksen, Baste, Hetland, & Reme, 2018).

Looking across all age groups, few studies have examined adaptations to IPS for people with common mental health problems, or problems that are mild or moderate (Bond, Drake, & Pogue, 2019; OECD, 2015). A recent review and meta-analysis assessed the effectiveness of a range of interventions aimed at enhancing return to work for people off work because of high-prevalence mental disorders (including anxiety, depressive and stress-related disorders) (Mikkelsen & Rosholm, 2018). Results showed an overall relatively small but significant and economically important intervention effect on average (pooled effect size 0.14, 95 percent CI 0.07 to 0.22).

The meta-analysis found strong evidence for effectiveness for programmes targeting stress, and for particular programme elements, including contact with the workplace, and the use of multicomponent interventions. There was also moderate evidence for interventions that provide support for 'graded' return to work. Organisational change (defined as enhanced collaboration or integration of central players) was not found to be associated with success (Mikkelsen & Rosholm, 2018).

Therapy did not appear to have an impact on return to work in the meta-analysis. This conclusion remained valid when examining the evidence for the most prevalent therapy (cognitive behavioural therapy or CBT) by itself (Mikkelsen & Rosholm, 2018). Alongside these results, in a systematic review of evidence on the effectiveness of workplace-based return-to-work interventions, CBT that focused on work-relevant solutions for mental health conditions had a strong level of evidence for a positive effect, whereas traditional CBT programmes had a strong level of evidence indicating no effect on reducing lost time from work (Cullen et al., 2018).

Only two of the interventions reviewed by Mikkelsen & Rosholm (2018) involved adaptations to IPS for adults with common mental health problems (these studies were not focussed on young people). Both studies applied the IPS principle of integration in a different way to accommodate this group. Results were mixed (Box 1).

Box 1: Recent RCTs studying IPS adaptations for adults with common mental health problems

The Norwegian 'At Work and Coping' (AWaC) trial integrated work-focused Cognitive Behavioural Therapy provided by therapists with IPS job supports (where these were needed) provided by employment specialists. AWaC was provided by the Norwegian Welfare and Labour Administration. Participants included people who were having difficulties in employment but were still working. People already receiving ongoing psychotherapy elsewhere were excluded. At 12 months, the proportion of people who increased or maintained their work participation was higher in the AWaC group than in the control group (44.2 percent vs 37.2 percent). The difference between the AWaC group and the control group was largest for those on long-term benefits at baseline (24 percent vs 12 percent). This was the group most likely to receive the IPS supports. For the subgroup on long-term benefits, the stronger effect sizes translated to a large positive economic net return. The study also found the programme significantly reduced some mental health symptoms and increased health-related quality of life. The effect on these outcomes was not larger for the subgroup on long-term benefits (Reme, Grasdal, Løvvik, Lie, & Øverland, 2015).

The Danish 'IPS modified for people with mood or anxiety disorders' (IPS-MA) study combined five services (i) individualised mentor support by an experienced mental health worker; (ii) career counselling by an experienced career counsellor; (iii) co-ordination of IPS-MA services provided, with mental health care provided elsewhere (but not close integration); (iv) impartial help relating to work (including legal advice); (v) contact with employers to help participants obtain jobs, and keep them (Hellström, Bech, Nordentoft, Lindschou, & Eplov, 2013).

Services were delivered by a provider outside of mental heath services and public employment services. People already receiving mental health treatment were not excluded. Mentors and career counsellors worked closely together. An adapted fidelity scale was used to measure fidelity to the intended model. Overall, fidelity results indicated that the method was well implemented. Results found no significant effect on entry into employment or education at 12 months (Hellström et al., 2017).

Reflecting on the contrasting results from the two studies, Hellström et al. (2017) noted that the severity of illness was similar between participants in both trials, and both studies reported similar overall effect sizes (with 6.6 vs 7.0 percentage point increases). However the smaller sample size of the second study meant it was unable to establish whether the difference was true effect (the number of participants had been determined based on the

number needed to detect an expected 15 percentage point increase).

Possible explanations for the smaller than expected effect size and lack of statistical significance in the second study included lack of integration of employment support with mental health care, insufficient focus on contact with employers in implementation, and low levels of disclosure resulting in few workplace supports to accommodate mental health needs. In addition, a large proportion of participants still displayed symptoms of anxiety or depression and a low level of functioning after two years, suggesting they may have needed additional mental health treatment to support a return to work (Hellström et al., 2017).

In Aotearoa New Zealand, because people with common, disabling conditions such as depression, anxiety, trauma and substance abuse, have to date received few publicly funded mental health services (Cunningham et al., 2018; He Ara Oranga, 2018), the principle of integration has had to be applied differently if IPS is to be offered to benefit recipients with these conditions.

An individually tailored employment support service that followed IPS principles, with the exception of integration, was funded by MSD for a period in the 2000s for Christchurch Work and Income (W&I) clients.

Of 49 young people who participated in that service, most were affected by depression or an anxiety disorder, and the majority were not receiving mental health care from the DHB. Despite a lack of integration with mental health services, the implementation achieved fair fidelity to IPS principles and practices overall, and had positive employment outcomes for the young people, including Māori, when compared to international IPS benchmarks. Authors of an evaluation concluded that although the less serious diagnostic mix of participants compared to IPS in other studies was likely to have contributed to the positive employment outcomes, the results were promising. They also observed that "staff could benefit from more training in youth-related issues, and staff from health services and employment services could collaborate to provide more coordinated and more youth-friendly services. Although young people seemed to do well in terms of employment commencements, maintaining engagement and increasing employment retention may require more youth-specific strategies" (Browne & Waghorn, 2010 p334).

In addition to their emphasis on better tailoring for young people, the Browne & Waghorn (2010) study highlights that it is not always clear how to implement the IPS principle of integration when the population group to be served does not have a mental health clinical treatment team. There has been no further Aotearoa New Zealand evaluation of an IPS service tailored to young benefit recipients with mental health needs who may not meet the threshold for publicly funded mental services.

The 2017 Budget initiative

The Government's 2017 Budget provided funding for MSD to purchase up to 1000 IPS places over four years. Of these, 500 places were for a trial of a service that would have good fidelity to IPS principles and practices in Adult Mental Health Services at Waitematā DHB in (Bence-Wilkins et al., 2019). The remaining 500 places were for young benefit recipients with mild or moderate mental health issues, involving an IPS adaptation to be co-designed by MSD and Odyssey House Trust in Christchurch. The adapted model was delivered by the Community Youth Mental Health Service.

Box 2: The Community Youth Mental Health Service

In July 2011, a group of non-government (NGO) services began meeting with Canterbury District Health Board (DHB) to canvass the need for youth mental health services in the region. A working group was established to develop a service to increase community

access, establish a coordination role, and establish the level of need.

A cross agency initiative was established, and an integrated Community Youth Mental Health Service (CYMHS) model was developed that would be mobile and available in a range of youth venues.

CYMHS is funded by the Canterbury DHB and run in conjunction with Purapura Whetu, a Kaupapa Māori health and social service provider, Odyssey House, and Stepping Stones Trust, and serves young people aged 13-19 who may be facing mental health and/or drug and alcohol issues. Referrals come from the DHB, GPs and schools. The age range is flexibly administered.

The service provides short-term intervention which includes assessment, treatment and support. CYMHS also coordinates and supports young people and families and whānau into longer-term treatment if required. Young people can be seen at school, health clinics, or at home.

The intention of the CYMHS initiative was to build on a small pilot funded by the Christchurch Work & Income (W&I) region and delivered by CYMHS at the Riccarton W&I Service Centre in 2016. That pilot involved voluntary group-based motivational workshops for young people receiving a benefit as a result of mental health or addiction issues. The pilot had a strong 'Positive Youth Development' approach (Box 3), and some commonalities with the IPS principles of person-directed and individualised support. It had shown indications of success in improving participants' wellbeing and supporting them towards employment, but had not been evaluated.

Box 3: Positive Youth Development

"A major shift in the way that young people are viewed has been promoted through a Positive Youth Development approach… This approach is increasingly shaping youth research, policy and practice … and frequently emerges in conversations about the most effective ways for working with young people…

One of the core principles that underpins Positive Youth Development approaches is that every young person has the potential to contribute positively and productively to, and benefit in healthy ways from, the widest ecological contexts with which they identify. In this sense Positive Youth Development practices emphasise providing services and opportunities that focus on supporting young people to develop a sense of competence, usefulness, belonging and empowerment. Positive Youth Development strategies focus on giving young people the chance to form relationships with caring adults, to work with their strengths, to build skills, exercise leadership, and help their communities" (Higgins et al., 2019, Appendix 1).

A requirement of the 2017 Budget 'Track 1' process under which the two IPS initiatives were funded was that they should be evaluated as they were implemented, with a focus on understanding and demonstrating effectiveness in improving outcomes. To meet this requirement, staged mixed-methods studies are being undertaken.

Methods

For Take Charge, the initial stage involved developing and evaluating a small prototype. Odyssey House, MSD Service Delivery and Research & Evaluation teams, and the W&I Canterbury Youth Shop at the Linwood Service Centre collaborated to develop the prototype. Design was informed by IPS research evidence, elements of the motivational workshops from the 2016 pilot that had been seen as successful, and the youth development and practice experience of the Odyssey House clinicians and the W&I Service Centre manager.

The decision to prototype the initiative was informed by the prevention science approach to evaluation which emphasises the value of piloting, and the need to gather qualitative

insights to enable the client experience of a programme to inform its development (Fergusson, Mcnaughton, Hayne, & Cunningham, 2011).

The prototype stage was an implementation study designed to explore client experience, cultural acceptability, fit with best practice, IPS fidelity, and reach, retention, activities and outcomes, and to provide learnings for the main trial.

Implementation study activities included a formative evaluation of the prototype by a research team that had not been involved in developing the prototype. This included in-depth interviews with participants, Take Charge staff, and stakeholders, literature and document reviews, and practice observations. A full report on the formative evaluation is available (Higgins et al., 2019).

Degree of IPS fidelity in the adapted approach was assessed by way of an independent fidelity review conducted using the IPS-25 Fidelity Scale (Becker, Swanson, Bond, & Merrens, 2011). This scale assesses adherence to IPS principles and practices. A full report on the fidelity review is available (Stephenson & Bell, 2019).

Other activities included collection and analysis of de-identified monitoring data and de-identified data on quality of life over the course of participation assessed using the Aotearoa New Zealand version of the WHOQOL-BREF (World Health Organisation Quality of Life) tool. An anonymous client satisfaction survey was also administered in an effort to assess the acceptability of the prototype to clients, including its cultural acceptability. However the number of surveys returned was too small for the results to be informative.

Ethics approval was granted by the Southern Health and Disability Committee (Ethics Ref 18/Sth/61). All participants were provided with an information sheet describing the study, had the opportunity to discuss Take Charge and what it involved with the Take Charge team before deciding whether to participate, and signed a consent form prior to participating in the prototype.[2]

[2] The information sheet and consent form are attached as Appendix 1.

3. The Take Charge prototype

Contracting and establishment

In early 2018, MSD contracted Odyssey House to deliver the prototype. The contract set out performance and data requirements for contract monitoring, and requirements for provision of de-identified data for the evaluation.[3] The prototype was intended to involve 45 participants, and be run for nine months, starting May 2018.

Funding for the prototype allowed the CYMHS to recruit an 'Employment Consultant' and to second a CYMHS social worker and registered addiction treatment practitioner as the 'Take Charge Co-ordinator'. The Take Charge Co-ordinator filled the roles of programme co-ordinator and IPS mental health clinician.

The Employment Consultant and Take Charge Co-ordinator made up the Take Charge Team. The Take Charge Co-ordinator received peer support and advice from the CYMHS treatment team, and attended their weekly meeting to discuss concerns. The Take Charge service operated from Ferry Road in central Christchurch. The team worked closely with the local W&I Youth Shop, and established a regular weekly time slot for Take Charge clients to see W&I case managers for employment-related or financial assistance.

Regular project oversight meetings involved the MSD Client Experience and Service Design and Research & Evaluation teams, the W&I Youth Shop Service Centre Manager, the CYMHS manager, and the Take Charge Co-ordinator. These meetings were used to monitor recruitment, address prototype design challenges, and co-ordinate evaluation activities.

Box 4: Economic context

At the time the prototype was getting underway, the Aotearoa New Zealand economy was characterised by low inflation and low unemployment (4.5 percent in the June 2018 quarter).[4] Annual GDP growth was 3 percent.[5] The unemployment rate in Canterbury was slightly below the national rate at 4.0 percent. The rate had been well below the national rate for several years after the 2010-11 earthquakes (likely partly reflecting more employment opportunities with the rebuild of Christchurch).

Participants and recruitment

Participation in Take Charge was voluntary. Those eligible to participate were in receipt of a benefit – either receiving Job Seeker Support – Health Condition, Injury or Disability (JS-HCID) or Supported Living Payment (SLP) – and had a medical certificate indicating they had a stress-related disorder, depression, an alcohol or drug disorder, or another psychological or psychiatric condition. People with a diagnosis of bipolar disorder or schizophrenia, or any significant co-occurring physical health problems or disabilities were not eligible to take part. Clients were also excluded if they were pregnant, or if there was a trespass order against them.

It was expected that eligible clients would have a range of different mental health conditions of varying levels of severity, but these would generally have a mild or moderate

[3] It made no provision for further funding, with the intention that contracting for the main trial would be contingent on indications of success in the prototype stage.

[4] See www.stats.govt.nz/information-releases/labour-market-statistics-june-2018-quarter.

[5] See www.stats.govt.nz/indicators/gross-domestic-product-gdp.

impact and most likely be anxiety or mood disorders. It was intended that clients who, after referral by MSD, were assessed at intake by the Take Charge Co-ordinator as having a serious mental health condition would be excluded. Acceptance was based on an individual clinical assessment with each participant which included consideration of clinical supports already in place. (In practice, no-one was excluded at this stage.) Those aged 18 and 19 were the target group for the prototype, with the intention of opening the service up to those aged 18-24 years in the main trial.

Recruitment occurred in five intake waves from May to September 2018. Numbers in each intake were lower than expected, and intakes four and five were added to achieve the intended number of participants. The initial approach to recruitment involved case managers 'cold calling' (by telephone, text and email) benefit recipients who appeared to meet the eligibility criteria, and inviting them to attend an information seminar at a W&I office facilitated by the W&I Youth Shop manager and the Take Charge Co-ordinator. Case managers making the calls were provided with a list of potential candidates from administrative data. They then carried out security checks and were able to call the Take Charge Co-ordinator to check suitability without sharing any identifying information before beginning the cold calling.

This approach proved to be administratively burdensome and had a low success rate in positively engaging clients, with many not picking up or responding, while some others who agreed to attend over the phone did not then attend the information seminar. In response, an alternative approach to the initial invitation to participate was adopted. This involved case managers promoting Take Charge to those who met the eligibility criteria as part of routine face-to-face and phone-based case management. This approach was used alongside cold calling for the third and fourth intakes. For the final intake, it was the sole recruitment method, and was seen as more successful.[6]

In addition, some clients who were interested in the service signalled their reluctance to attend group sessions. After the second intake wave, the recruitment process was adapted so that enrolment took place at the W&I office via one-on-one or small group information sessions with the Take Charge Co-ordinator. Clients recruited in this way were more likely to go on to enrol in the programme than clients who attended an information seminar. They appeared to appreciate the opportunity to speak directly with the person they would be dealing with if they went ahead. Family and whānau and other support people were able to participate in the information sessions, and young people were encouraged to talk with their family or whānau about taking part in the study.

Clients attending an information seminar (intakes 1-2) or one-on-one or small group information session (intakes 3-5), were provided with an Information Sheet (attached in Appendix 1) giving details of the study and its aims, and the information sharing that would occur if they participated.[7]

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[6] In the first four intakes, clients registered in all Christchurch city service centres were invited to participate by cold calling, and clients at the Linwood service centre (serving the east side of the city) were also invited to participate through routine face-to-face and phone-based case management after the second intake. In the final intake, referrals were sought though routine face-to-face and phone-based case management from all Christchurch city service centres and Rangiora (a small rural centre outside Christchurch). Additional information sessions and TC group workshops were held in Rangiora.

[7] In waves 1-2, information seminar participants interested in participating who consented to their contact details being shared were then contacted by phone by the TC Co-ordinator and reminded about the first group workshop.

In conversations with potentially interested young people, the Take Charge Co-ordinator talked about the chance to explore education and work goals and get help to address health concerns within a supportive environment. W&I provided assistance for travel to the information seminars and sessions and to Take Charge workshops if this was needed.

Enrolled participants were those clients who provided written consent for participation in the study. Prior to enrolment, participants would have met the Take Charge Co-ordinator at a one-on-one or small group information session, or attended at least one group-based motivational workshop. The Consent Form is attached in Appendix 1.

Intervention

Some IPS practices and principles were intended to be applied in Take Charge without modification. These programme features are summarised in Box 5.

Box 5: Take Charge features in common with IPS principles and practices

Focus on competitive employment:	Employment in mainstream competitive jobs, either part-time or full-time, is the primary goal
Attention to client preferences:	Job search is consistent with a person's preferences
Systematic job development:	Employment Consultants develop relationships with employers and seek out work opportunities based on a person's work preferences
Work incentives planning:	Benefits counselling, including advice on how working will affect benefits, supports the person through the transition from benefits to work
Rapid job search for competitive job:	Initial employment assessment and first employer contact within 30 days of employment support starting

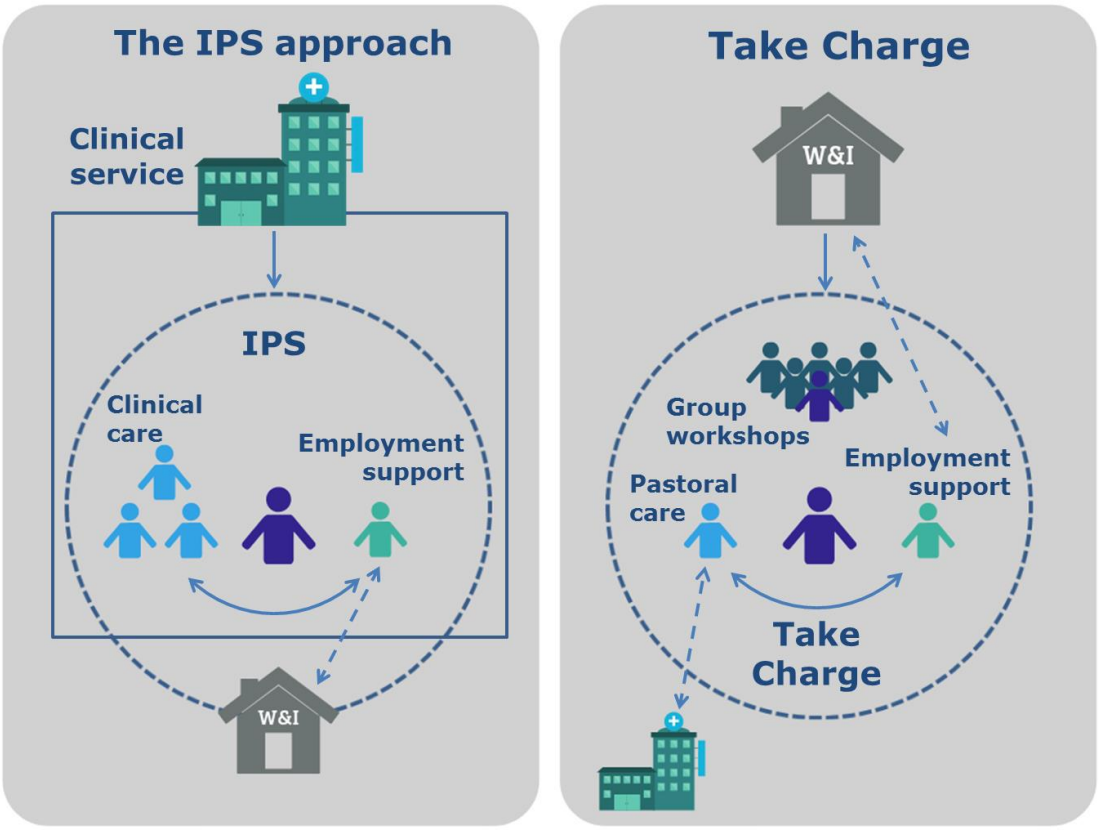
Programme features that varied the way that IPS principles and practices were applied are summarised in Box 6 and discussed in more detail below. In most cases, the way IPS principles and practices were applied was tailored to the target group, or Take Charge was adapted in a way that was congruent with IPS principles and practices. In a non-congruent departure from IPS practices, support was time limited given the short duration of the funding for the prototype. If the young person had not found work by the end of the prototype (that is, within 6 to 9 months), or no longer required regular support to maintain employment, they would be transitioned back to W&I.

Box 6: Take Charge features that tailor or adapt application of IPS principles and practices

	IPS	Take Charge application of IPS principle and practices
Target group:	People with serious mental illness receiving mental health treatment and care from a publicly funded mental health treatment team	Young benefit recipients with mild or moderate mental health problems, and no serious mental illness or significant co-occurring physical health problems or disabilities
Integration of mental health and employment services:	IPS usually integrates employment support with mental health care and is embedded within an existing publicly funded mental health service that is already providing IPS participants with mental health care. Referrals to IPS come from the clinical team within a mental health service.	A new service was created that brings together support with mental health and employment support for people in the target group who want help finding work Referrals came from the benefit agency Pastoral care (mentoring, counselling, social support, and support to access mental health and addiction services) was provided by the Take Charge Co-ordinator Those needing more intensive mental health treatment were under the care of, or referred to, other services
Eligibility based on client choice:	Zero exclusions apply from referral through to IPS service delivery (noting that to be referred, a person must be receiving mental health care)	Adapted in that eligibility criteria were applied in the referral process to limit access to the target group Zero exclusions applied once participants were enrolled in Take Charge
Individualised job supports:	Support is time-unlimited and individualised to both the employer and the employee May include support for education for youth	An IPS non-congruent adaptation was time limiting of supports due to the short-term nature of the prototype funding IPS congruent adaptations included additional optional group-based workshop components; a flexi-fund; some support for education; and taking a Positive Youth Development approach to service delivery

Integration of mental health and employment services. The way that the IPS principle of integration was applied involved creating a new service that allowed young benefit recipients, many of whom were not expected to meet the threshold for publicly funded mental health treatment, to access support for their mental health and employment needs. Referrals came from W&I (Figure 1).

Figure 1: The IPS and Take Charge approaches to integration



This adapted model was not fully integrated as clinical responsibility tended to remain outside the Take Charge team. The Take Charge Co-ordinator provided counselling sessions where needed, monitored participants' mental health and referred them to additional supports where appropriate, seeking advice from the CYMHS treatment team and their support to facilitate service access. With client consent, the Take Charge Co-ordinator directly liaised with participants' GPs and other specialists or agencies providing treatment and care.

> *"Support given was highly responsive in the sense of being offered, as much as possible, when and where each young person needed it, through multiple communication channels including face-to-face meetings, phone calls, text messages, and the accompanying of young people to various appointments with other services. While being responsive in all these ways, the Take Charge staff were clear about not offering crisis support; this was explained at an early stage to each young person and they were given details about how to contact the crisis service should they need to"* (Higgins et al., 2019).

In Take Charge young people could access pastoral care and employment and education supports in combination or in a sequence determined by what mattered for them. If, during their individual clinical assessment, the young person said they wanted employment support, the Take Charge Co-ordinator introduced them to the Employment Consultant. An introduction to the Employment Consultant could also occur at the group sessions, or following on from of these sessions. Once the young person was introduced to the Employment Consultant, job search was rapid.

Eligibility based on client choice: When IPS sits within an existing mental health service for people with serious mental illness, no exclusions should apply from referral through to IPS service delivery. However access to IPS service *is* being targeted by virtue of the service only being available to those under the care of the mental health service. In

Take Charge, eligibility criteria needed to be applied in the referral process to limit access to those with mental health needs, and to avoid referring clients with mental health needs that were not able to be met by Take Charge. No exclusions applied once participants were enrolled.

Individualised job supports: A key adaptation was the addition of group-based motivational workshops focussed on skills and strategies that could help participants meet their employment goals, delivered by the Take Charge Co-ordinator and attended by the Employment Consultant. These were spread over five sessions spanning the initial 2.5 weeks of enrolment and covered: (i) understanding anxiety and depression; (ii) goal setting – the importance of structure and routine; (iii) presenting the best you can be – role-play and interview skills, CV preparation, hygiene and body language; (iv) conflict resolution/communication skills – including family systems and how they impact the choices we make; and (v) recognising problematic alcohol and drug use. There was flexibility in the workshop content. If the co-ordinator could see that participants would benefit from tools and techniques to manage anxiety or support with self-esteem then that content would be delivered.

Consistent with IPS practices, support with employment and education after the workshops was tailored to individual needs. At their first meeting, the Employment Consultant worked to establish rapport with the young person and identify their employment or education goals. They then continued to work together to help the young person identify jobs that interested them and take steps to prepare for and find work. In some cases, when the young person was keen to study, the Employment Consultant would help them with this.

Alongside working with young people, the Employment Consultant engaged with potential employers, and more generally 'tested the waters' with employers by discussing with them the possibility of taking on a young person with mental health issues (Higgins et al., 2019).[8]

In designing the content of Take Charge, CYMHS used models designed to meet the needs of Māori participants, and consulted extensively with the Odyssey House Kaumātua and Cultural Committee. Take Charge was intended to embody the Te Whare Tapa Whā model (Durie, 1985) and emphasise the importance of whakapapa (where you are from). The service provided access to a Kaumātua, a cultural advisor and to Purapura Whetu, a kaupapa Māori health and social service provider, to ensure participants could connect with their culture. An anticipated essential part of the success of the prototype was connecting with employers that had a focus on diversity and inclusion as part of their employment policies, and breaking down negative stereotypes with other employers.

The Take Charge team administered a flexi-fund of up to $800 per participant for direct purchasing of services or products that would support movement into employment and job retention. This included support for participants to make changes to their lifestyle that would improve their ability to gain and maintain employment (eg healthy eating or exercise).

In another addition to the standard IPS model, the Take Charge team used a Positive Youth Development approach when delivering services.

[8] The process followed by the EC was based on the "Effective Employer Engagement" model from Australian-based organisation GIVEN . This model has been workshopped in Aotearoa New Zealand in conjunction with the New Zealand Disability Support Network and has been used by supported employment providers.

4. Participants, retention, and activities

This section presents de-identified data gathered as part of the evaluation.

Participants

The five intake waves spanned May to September 2018. Across the waves, 65 clients attended a Take Charge information seminar or a one-on-one or small group information session.[9] Of these clients, 44 (68 percent) consented to participate and were enrolled in the service.

The prototype enrolled slightly more young men than young women (Table 1). A quarter of participants were Māori. At intake, all were in receipt of JS-HCID and the majority (91 percent) were not receiving any mental health care other than that provided by their GP.

Table 1: Characteristics of prototype participants

		n	% Total
Gender	Male	24	55%
	Female	20	45%
Ethnic group	Non-Māori	33	75%
	Māori	11	25%
Benefit type	JS-HCID	44	100%
	SLP	0	0%
Mental health treatment or care being received at intake	Specialist care provided by a DHB or DHB-funded mental health team	3	7%
	Private counselling funded by ACC	1	2%
	Under the care of a GP only	40	91%
Total		44	100%

Participants' quality of life

The New Zealand version of the shortened World Health Organisation Quality of Life (WHOQOL-BREF) questionnaire (Box 7) was used to measure participants' quality of life at intake and at three- and six-month follow ups. The questionnaire comprises 31 items. Participation was voluntary.

[9] The total number of referrals is unknown, and no record was kept of the number of clients who were offered the service but either didn't answer the phone, declined to attend, or did not attend the follow up session.

Box 7: The WHOQOL-BREF

WHOQOL tools are designed to measure the extent to which people, irrespective of their health status, feel satisfied with their health and well-being. The short form version, WHOQOL-BREF, was developed to reduce response burden (WHOQOL Group, 1994).

Respondents are asked to rate on a scale of 1-5 how they have been feeling in the previous two weeks, in response to each question. For example, one of the questions under the psychological domain asks participants to rate how much they enjoy their life, from 1 (not at all) to 5 (an extreme amount). Scores for each question within a domain are combined to provide a domain score.

A number of countries have developed additional national items to incorporate facets of quality of life that may be relevant for specific cultural groups (Billington, Landon, Krägeloh, & Shepherd, 2010; Krägeloh et al., 2013). A NZ version of WHOQOL-BREF has been developed with additional items in the social and psychological domains. These include a question related to feelings of belonging, which aligns with the influence of collectivism of Māori culture, and expectations placed on a person, which aligns with Māori and Polynesian culture, where values and obligations are centred around the extended family and community (Krägeloh et al., 2016).

Domain:	**Question area:**
Physical health	Pain and discomfort Energy and fatigue Sleep and rest Activities of daily living Dependence on medicinal substances and medical aids Mobility Work capacity
Psychological wellbeing	Bodily image and appearance Negative feelings Positive feelings Self-esteem Spirituality / Religion / Personal beliefs Thinking, learning, memory and concentration Expectations placed on you *** Respected by others *** Manage personal difficulties *** Control over your life ***
Social relationships	Personal relationships Social support Sexual activity Belonging ***
Environment	Financial resources Freedom, physical safety and security Health and social care: accessibility and quality Home environment Opportunities for acquiring new information and skills Participation in and opportunities for recreation / leisure activities Physical environment (pollution / noise / traffic / climate) Transport

*** New Zealand national items

Three-quarters of participants (34/44) completed the questionnaire at entry to the programme. Table 2 shows the baseline entry WHOQOL-BREF domain scores transformed from raw ordinal scores to interval scores for the 30 participants who completed the questionnaire in full (Krägeloh et al., 2016). The number of questions in each domain varies, and as a result means cannot be compared across domains. Comparison with a representative youth cohort is not possible because reference values including the NZ items for a sufficiently sized youth sample have not yet been fully developed.

Table 2: Baseline NZ WHOQOL-BREF domain scores (including national items) at entry (n=30).

Domain	Mean	Standard deviation
Physical health	19.3	2.9
Psychological wellbeing	32.0	4.1
Social relationships	10.3	2.5
Environmental	22.4	2.9

Relatively few participants completed the questionnaire at later stages. At three months only 18 of the 44 participants completed the questionnaire and at six months only nine of the 25 participants who could be followed for six months from entry[10] completed the questionnaire. In addition, there was missing data within questionnaires. In total, WHOQOL scores at entry and at three months could be compared for only 15 of the 44 participants. This small and potentially selective sample meant we were unable to reliably examine changes in quality of life over time for participants.

Retention

The proportion of participants retained in Take Charge (receiving employment support, pastoral care, or both) for at least three months from enrolment was high at 89 percent (39/44), although for some participants the level of engagement varied within the period.

All five participants who exited the Take Charge service before three months left within the first two months of enrolment: two had limited engagement in their first month of enrolment and subsequently withdrew due to illness; one voluntarily exited as they felt they were not getting the help they needed, one moved out of the area; one was discharged for security reasons.

For the smaller number of participants who were able to be followed for at least six months from enrolment, the retention rate at six months was 80 percent (20/25).

Activities

Group workshops were relatively well attended, with 80 percent (35/44) of enrolled participants attending at least three sessions.

Participants required different levels of support from the Employment Consultant and Take Charge Co-ordinator and there was considerable variation in participants' monthly engagement with the two team members. Excluding time spent with the Take Charge team in the group workshops:

- recorded time spent with the Take Charge Co-ordinator varied from no engagement to 16 hours in a month, and the time pattern was variable but generally tapered after the first three months (this included all interactions including phone calls, face- to-face meetings, and time spent corresponding via text messages and emails)
- recorded time spent with the Employment Consultant ranged from no engagement to 18 hours in a month, with highest levels of engagement in the second month of enrolment.

[10] As at January 2019.

Flexi-fund payments were primarily made for transport, work clothing and phone-related costs. Other common uses were related to improving participants' health and wellbeing to support work, including nutritionist appointments and gym memberships.

5. Formative evaluation findings

Formative evaluation of the prototype was undertaken by researchers from the Collaborative Trust for Research and Training in Youth Health and Development in partnership with Ihi Research (Higgins et al., 2019). It involved observations and document review, 29 interviews with young people who participated in the prototype (14 immediately following the workshops, and 15 three or more months later), and interviews with three whānau or family members supporting the young people, and with 12 staff involved in the design and delivery of the prototype. Overall, 26 of the 44 young people who participated in the prototype participated in at least one interview. While the proportion of participants approached to be interviewed who consented to be interviewed was high (26 of 31 approached, 84 percent), it was not possible to interview those who did not wish to take part in the Take Charge programme.

The formative evaluation also drew on research evidence on best practice for working with young people with mild or moderate mental health or substance use problems, and best practice for supporting the transition of young people into employment (Box 8). Here we summarise findings related to referral and recruitment, staff roles in Take Charge, the complexities of context, and workshop delivery and content. More detail is available from (Higgins et al., 2019).

Referral and recruitment

The formative evaluation identified a number of ways in which referral and recruitment for the prototype did not align with best practice.

Cold calling created anxiety for many interviewees and is likely to have been responsible for the initial low take-up rate (Higgins et al., 2019). As noted in Section 3 of this report, the recruitment process was amended over the course of the prototype, and for the final intake this involved case managers offering the opportunity for clients to learn more about Take Charge as part of routine face-to-face and phone-based engagements with those who met the eligibility criteria.

An important theme in research on best practice is ensuring 'any door is the right door' when supporting young people, especially those with poor mental health. It is also well established that young people are most likely to take up a recommendation for a service if they have a trusted relationship with the person making the recommendation.

The fit of the programme for the young person – meeting the young person 'where they are at' – is another important theme. To achieve fit, it is important to understand young people in holistic terms (cognitive, emotional, social, cultural, spiritual, psychological, and physical) and to be attentive to the issues that will 'bring them into the room' (Higgins et al., 2019). For some of those interviewed, Take Charge was an excellent fit. However one consequence of the referral criteria and process used in the prototype, and the early stage of development of the employment support, was that the fit was not always good. As discussed below, while the pastoral care that was offered worked very well for all those interviewed, the employment support worked well for some but not for others. Some participants were less ready, willing or simply too unwell to participate in employment support in a productive way, and they struggled with it or disengaged (Higgins et al., 2019). Based on the fidelity review findings discussed in section 7 below, employment support was not yet being delivered in line with evidence-based practices. As fidelity improves we would expect Take Charge to provide a better quality employment support service for people who may need more intensive employment assistance, including people who are currently experiencing mental health symptoms.

Box 8: Key themes from research on best practice

Working with young people (adapted from Higgins et al., 2019, Appendix 1).

Meet young people 'where they are at' in their development, and in what 'brings them into the room'.

Relationships matter, eg connection to:

- community, and family and whānau (in whatever form that may take)
- a significant adult who has their back.

Ensure 'any door is the right door', eg:

- remove stigmatisation and cost, be culturally responsive
- provide whānau-centred, youth-friendly and youth-centred services
- deliver integrated services, able to cater for any/multiple needs, taking a 'whole-of-person' approach

Be strengths based, eg:

- focus on overall wellbeing and developing strengths and positive youth development, not just on reducing problems/symptoms
- ensure the young person is actively involved and has autonomy over the services they engage in.

Models of recovery should allow for longevity of contact; focus on multiple outcomes, and see recovery as a journey.

'Ways of being with' should be flexible and responsive; 'high support/high challenge'.

Be systems-focussed – view the young person within the context of the wider systems within which they exist and acknowledge the role these systems play.

Supporting the transition of young people into employment (adapted from Higgins et al., 2019, Appendix 2).

Choice making:

- the 'career pathway choice' is not a single choice made once
- young people often engage in 'pragmatic rationality' in which decision making is part of a wider lifestyle choice shaped by context and culture and social relationships
- a key question is: who interprets the careers landscape with individual young people? (For example, what expectations do they have? Are these strengths-based?)

Identity work: identity is not fixed, and does not develop in a linear fashion.

Discovery and development of abilities is key in crafting career paths:

- this involves enhancing young people's learning capacities
- enabling them to construct learning identities can lead to the creation of aspirations, and the ability to engage with a career pathway
- concrete and achievable goals can assist in the context of identity work, as can excellent working relationships with careers educators.

Opportunities and structures are important, including:

- families and whānau, which provide relationships through which young people craft identities, have their aspirations shaped, gain trusted sources of information, and receive emotional and financial support for career decisions
- neighbourhoods which are important in providing a sense of future security when making career choices
- mentors in both education and employment domains
- labour market conditions/employment contexts and cultures.

Emerging literature suggests young people with poor mental health benefit when employment support programmes include a supported education pathway and an education specialist, recognise the importance of family, whānau and social contacts, and offer some forms of work experience.

A factor that may have contributed to poor fit in some cases was reliance at the point of referral on health and work capacity information recorded on the medical certificate held by W&I. This information made it difficult to gauge whether the young person did indeed fall into the 'mild-to-moderate' category regarding their health problems. It became clear as the prototype went on that for many participants their mental health was having a significant impact on their functioning. In addition, given the changeability of many of these young people,

> *"the categories 'mild, moderate and severe' were not always useful, especially when the only information came from a snapshot view of the young person by a GP or W&I staff member, rather than an understanding drawn from a longer-term relationship"* (Higgins et al., 2019).

Further, not all those interviewed understood that participating in the prototype was voluntary. At least one of the young people interviewed reported that they did not realise they had a choice to accept or reject Take Charge and others indicated that 'because it's W&I' they felt somewhat obliged to follow through.

The formative evaluation identified that referral and recruitment channels could be further developed to better align with best practice principles.

Staff roles – pastoral care

Based on the way interviewed participants described the support they received, the independent evaluators assessed the quality of the pastoral support to be high, and in keeping with internationally-accepted best practice principles for working with this group. The support described was youth-centred and youth-friendly, and took a 'whole of person' approach in which young people were accepted and met 'where they were at' in terms of their development and the issues they presented with. It was flexible and responsive to need.

Many interviewees were genuinely surprised at being offered this level and quality of support. All spoke of the Take Charge Co-ordinator with gratitude and enthusiasm. For some, the support was transformative in terms of building their confidence. When they had felt themselves blocked and unable to find a way forward, the supportive environment of Take Charge helped them see a way towards managing their mental health and embarking on employment search.

An important challenge reported by the team in working with these young people was their impulsivity and changeability across a range of psychological states and behaviours including *"feeling able to cope or not cope; being in work then disengaging from work; being in relationships then disengaging from those relationships; being completely out of contact with the Take Charge team for weeks at a time and then coming back into contact and seeking support to continue where they had left off"* (Higgins et al., 2019). This brought challenges associated with appointment 'no shows' and time spent seeking to re-establish contact. It meant progress was difficult to measure as it was often not linear.

Staff roles – employment support

Employment support was offered taking a high challenge/high support approach. This is an important element of best practice in working with young people, provided the level of support is adequate to the level of challenge (Higgins et al., 2019).

Some of the young people responded very well to this approach. They felt able to apply for jobs themselves and spoke very positively of the Employment Consultant, and of the level of support offered and confidence they gained from working in this way. Some found the approach too challenging for their current levels of mental ill-health, and some

disengaged from the process altogether, suggesting employment support could be better tailored to individual need.

In the prototype, the Take Charge Co-ordinator was not trained in employment support, and the Employment Consultant was not trained in mental health support. This was identified as an area for improvement.

Employment support was client-led, which aligns with the IPS principle of giving *attention to client preferences*. However,

> *"[a]n approach that focuses on encouraging the young person to go out and find a job, while client-led in one sense, can miss what works best for that individual if it does not engage with their developmental needs, or take account of their limited horizons and expectations… The result may be a job in the short term, but it is likely that the opportunity has been missed to engage that young person in a process of career development that will have long-term benefits"* (Higgins et al., 2019).

To better align with best practice for supporting the transition of young people into employment, a client-led approach needed to be supplemented with strategies to enable young people to broaden their horizons and build up a vocational imagination in relation to potential career pathways. The Employment Consultant was already taking this approach with some young people. Research on implementing IPS for young people has identified career counselling and supported education as important enhancements to IPS for young people (Ellison et al., 2015; Killackey et al., 2017).

The complexities of young peoples' lives

In addition to disrupted education, the lives of the young people enrolled in Take Charge tended to be characterised by sub-standard accommodation, difficulties finding suitable accommodation, a struggle with finances, and no ready access to transport apart from public transport (which their levels of anxiety often discouraged them from using). Many had little or no knowledge of how to cook or maintain a healthy lifestyle. Some had family difficulties, including parents with mental health issues.

Take Charge participants starting on the job search process faced an employment market somewhat reluctant to hire young people who may not be as work-ready as employers would like. Coupled with a societal stigmatisation of mental ill-health, this could make gaining employment an upward struggle for these young people.

Bringing this wider context into the analysis allows discussion of the full range of factors that contribute to these young people learning about working life, discovering what they want to do, and putting in place steps that enable rather than frustrate them in this process (Higgins et al., 2019).

Workshops – the group setting

Feedback about the group workshops from participants was largely positive. All of the young people interviewed supported the programme structure combining group workshops with pastoral support. Many reported that they initially felt anxious about being in a group setting. Some found it difficult to leave their house. But many who were interviewed said they found the experience better than they expected, and in discovering that they could manage, they grew in confidence and in their understanding of their mental health.

> *"It became evident during the workshops that the participants had no real understanding of mental health conditions such as anxiety and depression. Through the workshops, the Take Charge team offered knowledge about*

mental health, particularly about anxiety, while also normalising and destigmatising it. The benefit of offering this content, in a strengths-based way in a group setting, was that these young people came to see their ill health as more common than they had realised, as something that others around them shared.

The group setting also gave participants an opportunity for social connection with peers. The Take Charge team commented that participants tended to stay on for at least half an hour after each workshop to socialise with each other; this can be seen as a strong indicator that these workshops were successful in breaking down some of the isolation that these young people had experienced" (Higgins et al., 2019).

The workshops did not work for everyone and not all participants attended every session, although almost all attended at least one. Some of the young women reported feeling somewhat uncomfortable finding themselves in groups that were predominantly male.

Workshops – content

In interviews, the young people reported that they found the content of the workshops useful, although in the three month follow-up interviews most found it difficult to remember much specific content. Nevertheless, they were often able to mention one or two things they had learned from the workshops that they continued to use as tools for managing their health and social interactions and for structuring their day.

The daily structure and family systems workshops came in for favourable comment from some of the young people, while others felt that the addiction and drug use workshop was irrelevant to them.

The Take Charge team and some of the young people suggested cooking and nutrition, budgeting, and more employment-focused workshops could also be useful. Opportunities to further develop workshop content to align with best practice and evidence were identified.

Separate from the formative evaluation, participant testimonies were gathered by the Take Charge team. These are presented in Box 9 with the permission of the four young people involved. They speak to some of the themes from the formative evaluation relating to pastoral care, employment support and knowledge gained in the workshops.

Box 9: Take Charge participant testimonies

"My experience with Take Charge has been amazing. When I walked into the first group session I had no idea what I was walking into but I went in with an open mind and coming out of that first session I felt like I had learnt a lot and knew that coming here was the best decision I had made."

"I have got a lot of support, people to talk to, learnt new ways to cope with all sorts of situations. I've learnt so much in the group I don't know where to start along with making good friends. Good to have someone to talk to. Because of Take Charge I am looking more at work when with WINZ I wasn't motivated to do anything. My motivation both mentally and physically has sky rocketed. I have learnt how to budget which has been a big thing. I had an interview yesterday and I'm just waiting to hear back but I'm now aware of managing my mental health while being employed."

"I came into Take Charge as a very scared and anxious young person and I can happily say that the programme helped me hugely to become more confident in myself and my abilities in getting a job. I got a job after my first session with the Take Charge team and found all of the support and help that I got to be amazing. It was definitely scary coming into it but its most definitely worth it. I've had a huge change in my life and feel like a new person."

"Since getting support from the Take Charge programme I was able to land a part time job in a distribution centre, and also get lots of really good advice moving forward with developing my business. Now I'm starting to look at contracting out my work to other people because I'm getting too much. It was so great to get support from these guys, and just to know there are people out there who want to see us young people succeed is a real blessing. Thanks so much team!"

6. Cultural acceptability and responsiveness for Māori

One of the tasks of the formative evaluation of the prototype was to explore whether there was a need for changes to improve cultural acceptability, relevance and responsiveness. Addressing this question is important because poor cultural relevance, a lack of cultural knowledge, subconscious bias, and institutional racism in delivery could mean lower programme engagement and effectiveness for Māori, and higher levels of programme attrition (Harris et al., 2006; Harris, et al., 2012; Priest & Lockett, in press).

Māori participants who were interviewed responded positively when asked about inclusivity and respect in relation to culture. None commented that they felt less able to engage with or remain in Take Charge as a result of lack of cultural responsiveness. Non-Māori participants also responded positively about inclusivity in Take Charge with many commenting that it felt like a place where everyone was accepted and valued for who they are.

The formative evaluation found that an area for development was connection with whānau and family. Whānau-centred practice is a core element of cultural responsiveness. It focuses on empowering families as a whole, rather than treating individuals separately (Te Puni Kōkiri, 2015), and recognises that helping whānau to support their young person is a major contributor to wellbeing both for the young person and the whānau. Connection with family has also been an enhancement made to IPS for young people (Bond, Becker, & Swanson, 2019; Ellison et al., 2015). In the Take Charge programme, each young person was asked at the beginning of their participation whether they wished their family or whānau to be involved. Members of the Take Charge team met with whānau members of those participants who wished for this involvement. The team's engagement with family or whānau was appreciated, but it did not happen often. A recommendation from the formative evaluation was that opportunities should be sought to spread this support throughout the service for both Māori and non-Māori young people.

Group workshops opened with karakia, mihi mihi and whakawhanaungatanga through the acknowledgement of the role of whānau and peers. The young people responded well to the connections made by the Take Charge team between their own life stories and those of participants. They drew on participants' existing knowledge to identify strengths in their lives and were strengths-based in their use of language, in their normalising and destigmatising of anxiety, and in their constant positive feedback. They were respectful of differences in backgrounds.

However apart from karakia and mihi mihi, the content of the workshops was not particularly culturally diverse. Te Whare Tapa Whā (Durie, 1985) was mentioned but was not strongly integrated into the rest of the content. The evaluation team identified that it would be useful to cast an evidence-based lens over the workshop content, including in relation to cultural responsiveness (Higgins et al., 2019).

7. Fidelity to IPS principles and practices

Fidelity reviews are an integral part of good implementation of IPS principles and practices and are used as a developmental tool to help improve service quality.

Degree of IPS fidelity in the Take Charge IPS adaptation was assessed by an independent fidelity review conducted using the IPS-25 Fidelity Scale (Becker et al., 2011). The approach to fidelity assessment aligns with best practice (Becker, Drake, & Bond, 2014; Becker et al., 2011). The aim of the review was to establish a baseline assessment of the prototype and provide recommendations for increasing adherence to IPS principles and practices.

The IPS-25 Fidelity Scale has 25 items divided into three sections: Staffing, Organisation, and Services. Each item is ranked from 1 (no implementation) to 5 (full implementation). The overall score is categorised as follows: 115-125 = Exemplary Fidelity; 100-114 = Good Fidelity; 74-99 = Fair Fidelity; 73 and below = Not Supported Employment.

Rating information was collected from multiple sources including interviews with the Take Charge team members, clinical staff at CYMHS, 10 participants, and a selection of W&I staff. Assessment was carried out by trained independent assessors experienced in IPS implementation. IPS fidelity was assessed at the 'agency' and team level rather than the individual practitioner level. The review was conducted at the end of October 2018, when the Take Charge prototype had been in operation for six months.

Overall assessment and main recommendations

The prototype was scored at 71/125 on the IPS-25 fidelity scale giving it a rating of 'Not IPS Employment Support'[11] (Stephenson & Bell, 2019). While the prototype scored well on a number of items, several items were scored as 1 (no implementation) (Table 3).[12]

This result was not unexpected given the short period of operation, the significant fidelity non-congruent adaptations to IPS made by Take Charge prototype, and the small size of the Take Charge team for the prototype.

A common theme from the interviews with young people was that they found the programme accessible. They commented on the easy relationship with staff, and their ability to connect with them to have their needs met.

The reviewers commended the combined efforts and the 'whatever it takes' attitude and commitment of Take Charge team and the collaborative approach established with W&I. The prototype was developed quickly, with limited resources and limited IPS expertise. Reviewers observed that the programme had a strong health lens through which employment and health interventions were delivered, and that fidelity review recommendations would help Take Charge move closer to IPS best practice.

[11] A re-labelling of the 'Not Supported Employment' rating category to suit the context.

[12] Table 3 is adapted from Browne, Stephenson, Wright, & Waghorn (2009).

Table 3: Summary of fidelity to IPS principles and practices by item

Sub-scale	Item label	Item descriptor	Scale scores 5=maximum fidelity				
Staffing			**1**	**2**	**3**	**4**	**5**
1.	Caseload size	*Employment consultants have active caseloads not exceeding 20 clients*			√		
2.	Employment services staff	*Employment consultants provide only employment services*			√		
3.	Vocational generalists	*Each Employment Consultant delivers all phases of vocational services*			√		
Organisation							
1.	Integration of rehabilitation with mental health thru team assignment	*Employment consultants are attached to no more than two mental health treatment teams, from which 90 percent of their caseload is comprised*	√				
2.	Integration of rehabilitation with mental health thru frequent team member contact	*Employment consultants are in close proximity to the mental health team, and actively participate in shared team decision making*	√				
3.	Collaboration between Employment Consultant and W&I staff	*Employment consultants and W&I staff work collaboratively to help shared clients*					√
4.	Vocational unit	*The vocational unit consists of at least two full-time Employment Consultants and a team leader*	√				
5.	Role of employment supervisor	*Supported employment unit led by a supported employment team leader with outcome-based supervision*	√				
6.	Zero exclusion criteria	*No additional screening such as job readiness assessments. All clients interested in working have access*					√
7.	Agency focus on competitive employment	*Competitive work is promoted through multiple strategies*	√				
8.	Executive team support for supported employment	*Agency executives eg CEO support implementation and sustainability*				√	
Services							
1.	Work incentives planning	*Comprehensive, individualised work incentives planning is offered to clients*				√	
2.	Disclosure	*Employment consultants provide clients with accurate information and help them to decide what to share with an employer about their health condition*		√			
3.	Ongoing, work-based vocational assessment	*Initial vocational assessment that is then updated with information from work experience in competitive jobs*			√		
4.	Rapid job search for competitive job	*Initial employment assessment and first employer contact within 30 days of employment support starting*			√		
5.	Individualised job search	*Employment consultants make employer contacts aimed at making a good job match to client preferences*			√		
6.	Job development – Frequent employer contact	*Each Employment Consultant makes at least six face-to-face employer contacts per week*	√				
7.	Job development – Quality of employer contact	*Employment consultants build relationships with employers to facilitate a good job match for both client and employer*	√				
8.	Diversity of job types	*Jobs obtained are diverse in type and setting*					√
9.	Diversity of employers	*Clients obtain jobs with different employers*					√
10.	Competitive jobs	*Jobs are in the open labour market*					√
11.	Individualised follow-along supports	*Clients receive a variety of support based on their needs from a variety of people*			√		
12.	Time-unlimited follow-along supports	*Employment consultant support continues in a transitioned way*		√			
13.	Community-based services	*Services are provided mostly in the community and not office-bound*		√			
14.	Assertive engagement and outreach by integrated treatment team	*Assertive outreach is used to maintain contact with clients*				√	
Total			**71**				

The prototype was rated as fully implementing IPS (a score of 5) for the following.

- 'Collaboration between Employment Consultants and W&I staff' (Organisation item 3). The Take Charge programme had a highly collaborative relationship with the W&I Youth team at Linwood Centre, Christchurch, where they had access to W&I resources and expertise. Regular meetings were recommended as a mechanism for continuing to build strong collaborative relationships, share expertise, and discuss common issues.
- 'Zero exclusion' (Organisation item 6). The reviewers found no exclusionary practices were observed once young people were in the programme, with practice driven by client preferences.
- Three Service items: 'Diversity of job types'; 'Diversity of employers'; and 'Competitive jobs'.

The prototype was close to fully implementing IPS (a score of **4**) for 'Executive team support for supported employment' (Organisation item 8). Reviewers noted that leadership at Odyssey House, MSD and W&I were supportive of and committed to the IPS approach.

'Work incentives planning' and 'Assertive engagement and outreach' also scored **4**. Recognition that the risk of losing welfare benefits can discourage clients from moving into employment drives the 'Work incentives planning' item. The reviewer commented that Take Charge helps mitigate this risk by having a close working relationship with the W&I Youth Shop who provide advice and support, and by making use of the flexi-fund. Take Charge largely followed IPS best practice in using multiple strategies to establish and maintain contact with clients rather than terminating service if an appointment was missed. The reviewer recommended documentation of each outreach attempt.

Key recommendations for focus in the following 12 months related to integration of employment support with mental health treatment, the role of the employment supervisor and composition of the vocational unit, and job development.

Integration of employment support with mental health treatment

The Take Charge prototype design meant that employment support, or 'rehabilitation', was not integrated with mental health services (Organisation item 1). The reviewers pointed out that Employment Consultants must be integrated with a mental health treatment team that has clinical responsibility and refers people directly to the programme for Take Charge to score well on this item.

This aspect of the design also made it difficult to achieve the level of frequent team member contact and collaboration required to meet IPS best practice (Organisation item 2). One recommendation was to include the Employment Consultant in CYMHS multidisciplinary team meetings to learn about health interventions and discuss clients of concern. Another was to have separate agendas for mental health and employment focus areas at weekly review meetings of the Take Charge team.

Composition of the vocational unit and the role of the employment supervisor

The design of the Take Charge prototype meant it was not possible for it to score well on the Vocational Unit item (Organisation item 4) as the prototype only had one Employment Consultant working on their own rather than the required two or more Employment Consultants. It was also not possible to score well on the Role of employment supervisor (Organisation item 5), as the prototype did not have a staff member fulfilling all of the functions that would usually be the responsibility of an IPS supervisor (eg providing employment specific supervision, mentoring, and setting targets).

Recommendations made by the fidelity reviewers included increasing staffing, strengthening the composition of the team to better align to IPS practices, clarifying and strengthening the employment supervisor role within the team, and considering how the multiple roles currently covered by the Take Charge Co-ordinator could be delivered in an expanded service. Improvements to mentoring, training and access to peer and technical support were also recommended.

Job development

The prototype scored **1**, or no implementation, on both items for 'Job development–frequent employer contact, and quality of employer contact' (Services items 6 and 7). In terms of frequency of employer contact, the Employment Consultant was making two, rather than the required six, face-to-face employer contacts per week on behalf of clients looking for work.

A recommendation made by the fidelity reviewers was for the Employment Consultant to increase the number of employer contacts and ensure that the employer contact has hiring authority. Recommendations to improve the quality of employer contacts included being more strategic about which employers to visit and building relationships with employers based on client interests. Ongoing face-to-face visits with employers that built an understanding of their business and hiring preferences were recommended to keep abreast of job openings and test if the client and employer would be a good fit.

Other item scores and recommendations

The score was **1**, or no implementation, for 'Agency focus on competitive employment' (Organisation item 7). Full implementation of this item requires competitive work to be promoted to clients at all stages of programme involvement. The reviewer acknowledged that the prototype was in its early stages so there has not yet been an opportunity to meet some criteria. Key recommendations for ongoing improvement included posting information about Take Charge at relevant agencies (eg W&I) and developing a plan for clients to share their work stories.

Two items in the Services section scored **2**: 'Disclosure' and 'Time-unlimited follow-along supports'. The reviewer recommended a more systematic approach for Employment Consultants to talk with clients about disclosing their health conditions to employers (eg through use of a disclosure worksheet). The existing Take Charge practice was to address disclosure on job placement or when an issue arose at work. A more planned approach was also recommended for time-unlimited follow-along supports, with face-to-face support before a job starts and weekly contact during the first month of employment. Best practice for this item requires clients to be transitioned to step-down supports from a mental health worker once they gain steady employment.

Full details of the assessment criteria, reviewer comments, and recommendations are available from the fidelity review report (Stephenson & Bell, 2019).

8. Monitoring data on outcomes

The prototype stage of the study was not intended to measure the effectiveness of Take Charge in improving outcomes for the young people who participated. However information was gathered on the proportion who gained employment or took up study, and on changes over the course of their participation in their response to questions about quality of life. The Take Charge team also monitored referrals to DHB mental health services.

Employment and education outcomes

Within the first three months of enrolment, 36 percent (16/44) of participants had entered into some form of employment.[13] Of those who had commenced employment, one-third (5/16) had gained at least one full-time job. Alongside employment, four participants were studying or enrolled into study, or scheduled to begin outside the three month window.

As at the end of January 2019, 25 participants were able to be followed for six months from enrolment.[14] Of these participants, 64 percent (16/25) had commenced employment within the six month window. Of those who had commenced employment, 50 percent (8/16) had gained at least one full-time job.

While the employment outcomes for this small group need to be treated with caution, and small numbers meant equity of outcomes for Māori and non-Māori clients could not be examined, the overall six-month employment rate is close to the 69 percent six-month employment rate of young clients in the earlier Christchurch service for benefit recipients studied by Browne & Waghorn (2010).

As with the Browne & Waghorn (2010) study, a possible explanation for the rate of favourable employment outcomes in Take Charge is the less serious diagnostic mix of participants when compared to a more standard IPS service. On average they would be expected to have higher levels of employment without assistance. Another possible benchmark from the small number of international studies of IPS involving young people with serious mental illness is an employment and education rate of 69 percent over a six to 24 month follow-up (Rinaldi et al., 2010). This should be considered a 'low-end' benchmark, because of the less serious diagnostic mix of Take Charge participants.

Based on the formative evaluation findings, 21 percent (8/39) of the young people still engaged in the programme at the end of November 2018 had decided they wanted to pursue tertiary study and were being assisted towards this goal at various sites including Canterbury University, Ara Institute of Canterbury (Christchurch Polytechnic) and in the Whenua Kura (Māori Primary Industries Training) programme. The employment specialist also assisted some young people to explore opportunities for voluntary work and work experience (Higgins et al., 2019).

Referrals to DHB mental health services

Over the course of the prototype, 23 percent of participants (10/44) received some form of DHB specialist care. Mostly this involved referrals to psychiatric emergency services but also included referrals to anxiety and eating disorders clinics, and for a psychiatric review as requested by the GP.

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[13] Any employment includes full- and part-time work or working contract. Excludes unpaid job trials.

[14] Including those who were no longer in the service at the end of January 2019.

Triggers for referrals to psychiatric emergency services often appeared to be relationship difficulties, or grief or loss, and to reflect the existing changeability in the mental health of the group. In many cases, the Take Charge team was involved in facilitating service access.

9. Limitations

Limitations of the fidelity review are as follows.

- Fidelity scales have been found to have a moderate, yet important, role in predicting employment outcomes. However good programme fidelity is necessary, but not sufficient (Lockett et al., 2016), and factors not currently captured by the fidelity scale may be important (Lockett, Waghorn, & Kydd, 2018a).
- Cultural responsiveness was not taken into account by the fidelity scale used. Future evaluations could consider using a newly developed IPS fidelity scale for young people which includes questions about cultural aspects like family inclusion (Bond et al., 2019). Articulating and assessing best practice in cultural responsiveness in the Aotearoa New Zealand context is a priority area for further research.
- Some of the Take Charge adaptations which, from these emerging findings, appear to be successful and aligned with best practice in working with young people were not taken into account by the fidelity scale used.
- The small and time-limited prototype meant that, even without adaptations to the approach, ability to achieve fidelity to IPS principles and practices would inevitably be limited. The staffing numbers and ratios needed for high IPS fidelity could not be achieved, partly because the model required funding for both mental health care and employment support. Learning and development of partnerships have been found to be associated with successful implementation (Papworth, 2017), and these are likely to take more time than was available in the short window of the prototype.

Our study also has limitations in its ability to capture clients' experiences.

- Assessing the outcomes of interventions in mental health care in a way that captures what matters most to service users is important but also challenging (Thornicroft & Slade, 2014). We used the New Zealand version of the WHOQOL-BREF which has been validated, but not specifically tested for a population that is clearly identified as having health issues (Krägeloh et al. 2016). Changeability in engagement, mental health and ability to cope may make it less useful as a tool for assessing change for the Take Charge target group. It proved difficult to engage participants to complete the questionnaire at the three and six month time points. As a result of the low response rates and participant resistance, we plan to investigate alternative, lower burden, tools in the next phase of the study.
- Those who consented to participate in interviews for the formative evaluation may be a selective group. People whose experience was not positive may have been less likely to consent to participate or stay in the study long enough to be invited to participate.
- Only a very small number of family and whānau members were able to be interviewed. Findings and recommendations should be read in this light.

Finally, because there was no control group, it is not possible to say what might have occurred for the participants in the absence of Take Charge, and whether and to what degree the service contributed to the outcomes observed.

10. Discussion and recommendations

This section brings together discussion and recommendations drawing on the various strands of the study.

Continue to develop a valued service that fills an important service gap

Based on the promising results from the prototype, it is recommended that Take Charge continues to be developed with modifications that strengthen fidelity to IPS practices and principles and further develop the group-based adaptations that appear to have been successful, with other modifications that the evaluation findings identified as areas for improvement.

Strengthen best practice guidance for cultural responsiveness

Priest & Lockett (in press) highlight the "*paucity of vocational rehabilitation literature on attention to culture and supporting Māori people with mental illnesses into employment*" and, based on a recent implementation in Northland, describe ways that attention to culture can enhance IPS implementation. Further research to understand how IPS can work well for Māori and to learn from examples of successful delivery of IPS within cultural and mainstream services would be a useful addition to the evidence base. This research could consider whether useful mechanisms for documenting best practice in the cultural context of Aotearoa New Zealand would be additions to, or a cultural overlay[15] for, IPS practices and fidelity review scales.

Involve families and whānau or other significant support people where possible

Whānau-centred practice is a core element of cultural responsiveness. In emerging literature, connection with family has also been an enhancement made to IPS for young people (Bond et al., 2019; Ellison et al., 2015).

> *"To be culturally responsive it is important that the Take Charge team builds trusting relationships with whānau members, including whichever significant support people are present in the lives of the participants. Opportunities to involve whānau should continue to be sought throughout the programme. In scaling up it is important staff are culturally competent and technically skilled in order to adopt a holistic approach to supporting whānau aspirations ... Resource and capability needs to be provided to the Take Charge team to achieve this"* (Higgins et al., 2019).

Increase staffing and clarify staff roles

In a high fidelity IPS service for people diagnosed with serious mental illness, one Employment Consultant serves between 20 and 25 participants at any time, and an IPS team comprises at least two Employment Consultants and a full- or part-time employment supervisor. At the time of the fidelity review, the single Employment Consultant in the prototype was working with 29 clients, and the Take Charge Co-ordinator was working with a further 11 clients who could soon require employment support. A recommendation

[15] An example is the Āhuru Mōwai overlay for the Born to Learn curriculum (Cram et al., 2018).

for better meeting need and lifting IPS fidelity is to increase the size of the Take Charge team to include two consultants and a supervisor. Developing a full- or part-time IPS supervisor role is likely to improve oversight, upskill the team in the IPS approach, and provide mentoring for Employment Consultants (Stephenson & Bell, 2019).

Another recommendation was to consider the multiple roles held by the Take Charge Co-ordinator, how roles should be grouped together going forward, and what additional roles might be needed. This could involve hiring a full- or part-time IPS supervisor, adding mental health clinicians or developing capacity and capability to deliver supervision (Stephenson & Bell, 2019).

A key aspect of best practice in working with young people, and also an element of IPS principles and practices, is establishing ongoing relationships of trust, and continuity of one-on-one service provision. When the team expands it will be important for each young person to work with the same specialists (in mental health support, employment support and education support) throughout their involvement in the programme (Higgins et al., 2019).

Support young people with education and training where this provides a pathway for them to achieve their employment goals, and recognise participation in education or training as a successful outcome

Explicitly including participation in education as a successful outcome aligns with best practice in relation to the developmental needs of the young people. There is also an emerging IPS literature that suggests a supported education pathway is an important fidelity-congruent adaptation when IPS is targeted towards young people.

In that literature, having a separate education specialist, rather than combining this role with that of the Employment Consultant, is suggested (Higgins et al., 2019). In a small team, a separate education specialist role may not be possible. However allowing one or more team members to develop specialist skills in education support and share their knowledge with other team members may be an alternative approach, although this would inevitably dilute the impact and role of the Employment Consultant.

It will be important for the specialist(s) to have a good understanding of which courses are fully funded, potential sources of financial support, and key contacts within educational institutions who are well-placed to provide pastoral care to clients. If education is unfunded and participants have a high risk of dropping out, a possible unintended consequence is that they incur debt and are no closer to achieving their educational and employment goals (Ellison et al., 2015). Likewise, if participants do not have a person to contact within an institution they may find it difficult to succeed in education.

Build staff skills and training, and build understanding of how to support young people to broaden their employment horizons and expectations

Key recommendations to lift IPS fidelity are to improve access to IPS training for staff, and include the Employment Consultant in CYMHS multidisciplinary team meetings to learn about health interventions and be better able to coordinate health and employment support. Another is to have separate agendas for mental health and employment focus areas at weekly review meetings of the Take Charge team (Stephenson & Bell, 2019).

A recommendation from the formative evaluation is that it is essential for the whole team to have training in best practice in the two key domains of the programme (i) supporting

young people with mental ill-health and (ii) supporting young people in the transition to employment.

> *"This will mean adapting the employment support process to take more account of the mental ill-health of the participants, and will involve some training for the Employment Consultant in understandings of mental health and substance use issues.*
>
> *It will be useful for the whole team to have a good understanding of best practice in working with young people in transition to employment. This will involve understanding how to stimulate 'vocational imagination' and career competencies among young people with mental ill-health who may have very limited horizons and low expectations of themselves"* (Higgins et al., 2019).

Further develop integration with mental health supports and referral pathways

A recommendation from the fidelity review is to consider referral source design and how this could support a zero-exclusion approach in providing access to young people wanting to access employment and education support (Stephenson & Bell, 2019).

In the current service landscape, Take Charge needed to be created as a new low-threshold service to integrate employment support with mental health needs for young benefit recipients. Most were not already under the care of a mental treatment team, into which IPS employment support would typically be embedded, but an equivalent health team could be the CYMHS multidisciplinary team.

In the vision set out in the report of the Government Inquiry into Mental Health and Addiction and the OECD's country report on mental health and work, the future state for mental health services includes a continuum of supports, with expanded community-based and primary care mental health services that meet the needs of people currently below the threshold for publicly-funded mental health treatment (Government Inquiry into Mental Health and Addiction, 2018 p92; OECD, 2018). There is a need to explore how best to increase access to integrated mental health and employment support for these people, and the findings from Take Charge can add to the evidence base.

One useful modification to Take Charge that would move it towards a more integrated model is to enable referrals for young people already receiving mental health services from the CYMHS team. Another would be to explore the feasibility of additional referral pathways that strengthen connections with primary care, and other local mental health services.

> *"Paths into Take Charge could be by way of GPs or other health professionals. One of the challenges in using multiple paths is that health professionals may not know enough about Take Charge to recommend it. If alternative pathways are to be considered, it would be useful to have some discussions with health professionals, such as GPs, about the best way to make the Take Charge option known and available to young people.*
>
> *Evidence indicates that young people do best when the services they access are well connected and collaborate well together. For the referral paths to work well in the interests of young people it will be important for such connections and collaborations to be in place.*
>
> *It will be important to create a process of referral in which the source of referral is able to identify and articulate as much as they can about the*

needs of the young person to Take Charge staff so that they are able to respond accordingly.

Where possible this referral process should involve the young person and their family or whānau. This process can also provide the opportunity to learn more about the needs of the young person and to identify and include the important sources of support they are bringing with them on this journey" (Higgins et al., 2019).

Improve the W&I referral process

Reliance on health and work capacity information recorded on the medical certificate to identify a group with 'mild-to-moderate' needs who could benefit from Take Charge was problematic. Being out of work or education are both crucial needs, and He Ara Oranga highlights that the future of mental health and addiction services should not be based purely on a biomedical model (He Ara Oranga, 2018).

Assessing need through its impact on a person's functioning, particularly in terms of whether they drop out of school or work, becomes an important trigger to warrant the prioritisation of access to health services. This is also important information for public employment services, like W&I, to gather as part of the assessment and allocation process so as to match a person to the right intensity of employment assistance (OECD, 2018).

Reducing reliance on medical certificates in recruitment, and continuing the approach of recruiting as part of face-to-face and phone-based case management is recommended. A constraint on W&I referrals achieving good fit in all cases is the limited ability case managers have to establish and develop relationships with clients in the current case management model. Nationally, most young people receiving JS-HCID, for example, receive 'General' case management which involves in excess of 300 clients per case manager, and no one-on-one case manager-to-client relationship.[16]

The Youth Shop at Linwood is unusual in having support from the Service Centre Manager for a culture of learning and development aimed at building the team's capability to engage well with young people (Stephenson & Bell, 2019), and relatively lower numbers of clients per case manager. However caseloads remain high (80 clients per case manager) which limits the depth of the relationships that can be built.

Any move towards more intensive one-on-one case management relationships is likely to improve case managers' understanding of the young people's needs and readiness, and improve the suitability of referrals.

"If W&I offices across the city are to take [Take Charge] up, it will be important to consider how young people are contacted and by whom. Face-to-face contact with a trusted person will always be better than a phone call or a talk with an unknown person. As well, it will be important for staff to be knowledgeable about the programme and this may require some training or induction" (Higgins et al., 2019).

An ongoing system of training to improve mental health competence of W&I case managers and changes to increase case managers' access to mental health advisors would also support improved referrals (OECD, 2018, p22). The recent introduction of a mental

[16] Source: Unpublished tables prepared by MSD.

health advice line to assist case managers interacting with clients with possible mental health needs is a positive step.

So long as W&I remains a source of referrals, it will be important to emphasise and re-emphasise to clients the voluntary nature of the service. This is important for addressing ethical risks. It will also ensure that those who participate do so because they want the help offered. As noted in the formative evaluation, a small number of participants reported feeling obliged to participate (Higgins et al., 2019).

Expand access to all young benefit recipients wanting to work who want the supports Take Charge offers, regardless of benefit type and reason for claim

The Take Charge experience highlights that it is important that services to support people on benefits with mental health problems into work are delivered in a manner that is sensitive to mental health needs, and by teams that are well equipped to provide or broker support and additional services when required. Services for this group need to combine both mental health and employment supports.

The OECD's country report on mental health and work highlighted that the mental health issues of many welfare recipients go unrecognised. Survey data suggests that between 45 percent and 55 percent of all recipients of SLP, JS and Sole Parent Support have a mental health condition, almost irrespective of the type of payment (OECD, 2018).

A useful modification would be to open Take Charge up to young benefit recipients with mental health needs that can be met through primary or community mental health and addiction services rather than specialist interventions who want help to pursue employment goals, regardless of benefit type, and regardless of whether mental health issues are the reason for their benefit claim. Such an approach would be best applied in the context of one-on-one case manager-client relationships.

Allowing self-referrals from benefit recipients who meet the eligibility criteria may increase the potential for the service to 'snowball' as participants share their positive experiences with others who could benefit from the service. A more open, 'any door is the right door', approach to Take Charge access for benefit recipients, and wide distribution of flyers and posters across a range of possible referral venues, would promote early access, and be consistent with best practice.

Continue to monitor referrals to psychiatric emergency services for severe psychological distress and assess whether further service modifications are required

The service encountered greater levels of psychological distress among some participants than expected. This highlights the fluctuating and in some cases undiagnosed needs experienced by some in the target group, and the difficulty in assessing the degree of mental ill-health given the information available to the case managers referring into the service and the Take Charge Co-ordinator assessing participant suitability at intake.

Take Charge appears to have played an important role in facilitating access to more intensive mental health services for a group that is currently under-served. Available evidence shows that unmet need for treatment is higher than average among young people (Oakley Browne, Wells, & Scott, 2006).

Modifications aimed at improving referral pathways and processes are expected to improve the fit of the needs of participants with the services Take Charge is able to offer. It is recommended that the number of instances of psychological distress severe enough

to result in referral to crisis services continues to be monitored, and that an assessment of whether further service modifications are required should be carried out by the Take Charge team in consultation with CYMHS treatment team in each instance. This should be assisted by Take Charge working in a more integrated way with CYMHS clinicians.

Consider W&I assistance for a 'graded' return to work or transition to work that might involve part-time work as a first step

Most Take Charge participants who found work within three months of enrolment worked part-time. Meta-analysis suggests that support for graded return to work may result in more successful return to work interventions for people with high-prevalence mental health problems (Mikkelsen & Rosholm, 2018). A useful step may be to review benefit policy and W&I services and operational policy to ensure they support transition to part-time employment for people with mental health problems. For example, this could include examination of the thresholds for benefit abatement when a person has part-time employment, and the rule that to qualify for SLP a person cannot regularly work 15 hours or more per week in open employment.

Further develop workshops and document the model

The group workshops were beneficial to many participants, despite initial misgivings from some, and it is recommended these be continued. Ideally the future evaluation should focus on them, so that their role as an adaptation to IPS can be better understood. Some further development of content and delivery was suggested in the formative evaluation:

- some care should be taken with the mix of young people so that the groups are not too gender imbalanced (eg consideration could be given to having workshops for young women by themselves)
- depending on the group composition, some content might be better conveyed on an individual basis
- given the initial shyness and reluctance to engage among many participants, perhaps the delivery of the workshops could encourage even more interactive and participatory activities
- it would be useful to cast an evidence-based lens over the workshop content, including in relation to cultural responsiveness – ideally, this content should be multidisciplinary and trauma informed.
- any future employment focused workshops should also be evidence based
- the focus of the workshops tends towards an individualised medical model. Given the level of knowledge among these young people, some medical facts are important. Consideration should also be given, however, to a whānau-centred approach where the young person is seen as a member of a collective in which the collective's wellbeing enables the person to achieve quality of life, and also to an approach that places the young person with a wider social context (Higgins et al., 2019).

Greater involvement of peer workers (other young people who experience mental health and addiction issues) in the co-design and delivery of workshops could also be considered (Ellison et al., 2015). It will be important to ensure that practices like pre-vocational training and assessment that are not part of IPS and work against the principle of rapid job search do not creep into the content.

Preparation of documentation on the Take Charge adaptations and training materials for programme delivery staff would be useful. This is important to ensure that, if the service continues to show indications of success and funding is secured, it is on a pathway for

replication in other settings and being taken to scale (Bopp, Saunders, & Lattimore, 2013; Fergusson et al., 2011; He Ara Oranga, 2018; OECD, 2018).

Recognise and address high administrative load

The administrative load of Take Charge was heavy in the prototype due, in part, to the changeability of the participants' needs and levels of engagement. This meant time was spent following up with young people who had dropped out of contact, and recording their highly dynamic circumstances in case notes. The formative evaluation made a number of recommendations on ways to reduce administrative load (Higgins et al., 2019).

Resource IPS technical assistance and independent fidelity reviews

This evaluation highlights the value of independent fidelity reviews in providing information that can be used to lift the quality of IPS implementation. Technical assistance would be a useful means of ensuring that Take Charge delivers IPS, with adaptations. Both would be useful supports for expansion of the service. In the current study, fidelity review activity (and some limited technical assistance) draws on time-limited evaluation funding. In any future implementation, it would be good to see these activities as a routine part of service delivery, and funded and contracted for accordingly.

Acknowledge complexity and structural factors

The formative evaluation highlighted the need to take care to ensure that the Take Charge model adopted does not focus exclusively on the individual "*so that 'the problem' is defined to sit wholly with the young person and their mental health, and missing wider contextual factors*" (Higgins et al., 2019). Recommendations included:

- promoting a wider understanding, in the whole Take Charge team, of employer engagement processes and employment context and culture
- recognising that other contextual dynamics are also in play and should be understood, including family and whānau dynamics (both supportive and otherwise), and history of trauma.

11. Conclusion and next steps

Take Charge was valued by participants. It filled a significant gap in the current service landscape for young benefit recipients who are affected by stress, depression, anxiety, alcohol and drug addiction and other difficulties. Participants interviewed said the pastoral care from the Take Charge Coordinator and the knowledge they gained in the workshops, helped their understanding of their own mental health and, to a certain extent, their capacity to manage it (Higgins & Schroder, 2019). Of participants able to be followed for six months, two-thirds had begun employment. The service may have played a role in facilitating access to more intensive mental health services where these were needed.

Based on the promising results from the prototype, the Take Charge initiative will continue to be developed through the trial phase:

- Access will be expanded to 18-24 year olds in the Canterbury region with mental health needs that can be met through primary or community mental health and addiction services, who are in receipt of any main benefit, or at risk of losing employment and becoming benefit dependent, and who want help to find or keep suitable employment.
- The programme will aim to provide support to take up education on the pathway to work. Young people already receiving mental health services from CYMHS teams will be able to be referred to the service.

Future evaluation activities will include further fidelity reviews to assess whether, following modification, Take Charge delivers IPS, and continued monitoring. As numbers build, the proportion of Māori and non-Māori participants gaining employment and entering education will be monitored. A Māori-centred study is also planned, with the aim of helping funders, IPS providers, fidelity reviewers and IPS teams attend to cultural responsiveness.

Take Charge offers an exciting opportunity to further the science and practice of what works to support young people with mental health needs and addiction to successfully transition into employment.

Continued effort is needed to balance the delivery of IPS evidence-based practices with the modifications required for this specific population group in the Aotearoa New Zealand context, and this will be an important focus for ongoing delivery of the service, and for the next phase of the study.

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Appendix: Information sheet and consent form

Participation Information Sheet
Take Charge – Trying a new approach to finding work

We'd like you to help us find good ways to help young people like you into work.

What is the Take Charge study about?

Getting into work is a goal for many young people who are coping with mental health or drug and alcohol addictions. We know finding a job can be hard and work support can help.

We're inviting you to take part in a study and help us set up a work support service called **Take Charge**.

We're starting out small at first so we make sure we get it right. From the study we want to find out:

- how do people use a service like Take Charge?
- does the service work well or do we need to make changes?
- are people happy with the service?

The study will start with up to 45 people, at the Community Youth Mental Health Service 98 Greers Road, Burnside, Christchurch, 8440.

What will taking part involve?

- In the first 3 weeks you'll get to meet with a group of 10-15 people your age who have a mental health condition or substance addiction and are also interested in finding work. Your group will take part in five one–hour group workshops aimed at improving your health and finding work.
- The workshops will cover things like tools and techniques to manage anxiety and depression, daily structure, presenting the best you can be, family systems, understanding unsafe alcohol and drug use and barriers to employment.
- At the end of the first 3 weeks you'll start to have regular one on one meetings with your Employment consultant – someone who's there to get to know you and help you find the right kind of work for you.
- Your meetings with your Employment consultant will be to discuss and focus on your work goals and what jobs interest you. Then they'll help you look for work. When you meet, and the amount of time you spend with your Employment consultant will be based on your preference.

- If needed, you can also have one on one counselling sessions with the Take Charge coordinator (*********), who'll help you work through any barriers to employment.
- If you need it, you'll get help with transport and any other costs of starting work.
- Once you're in a job, your Employment consultant and ****** will stay in touch with you to support you in your job, if needed until the end of the study (February 2019).
- The Employment consultant and ****** will attend weekly meetings with the Community Youth Mental Health Services, and may have access to your mental health information where it's relevant to you finding work.

Any information sharing about you is subject to the same strict confidentiality standards as for all healthcare professionals. ****** will talk to you about how much information you'd like your Employment consultant and the Community Youth Mental Health Service to know about you, your whānau and your mental health.

What does the study involve?

The Ministry of Social Development is working to help us get our new Take Charge approach right.

To be able to do this, we'll need to share some of your information with them.

This includes:

- your name
- your date of birth
- the date you started to take part in the study
- the date you start any paid or unpaid work, the hours you worked and the work address
- support your Employment consultant and ****** give you to help you find work
- date you finish/exit the study and reason (if provided)
- flexi-fund payments paid to help you look for or to stay in work and
- other support or services that you are referred to.

The reason why we share your information with the Ministry of Social Development is so they know that the right people are being offered the opportunity to take part in this study, how you're getting on and whether Take Charge is working well to meet your needs and help you into the right kind of work. Information that identifies you will be stored safely within the Community Youth Mental Health Service and the Ministry of Social Development, and will not be shared further.

People who are experts in setting up this kind of service will look at our progress later in the year. This will involve talking to the Community Mental Health Service and also to your Employment consultant and Take Charge coordinator about how the service is going. They

may review records. They might also invite a small group of people from the study to talk about their experiences of the service. If you're invited to take part you can say 'no' and this won't affect the Take Charge service you get.

What are my rights?

- Taking part is voluntary – you don't need to take part. If you choose not to take part this will not affect your benefit or regular payments from Work and Income.
- Taking part or withdrawing from the study will not affect your benefit or any regular payments from Work and Income, unless you start paid employment.
- You may withdraw from the study at any time, without giving a reason.
- You can ask to see any information collected about you as part of this study at any time and can correct it if it's wrong.
- Your identity will be kept strictly confidential. Nothing which could identify you personally will be written or included in any reports on this study.
- A summary of the study's overall results will be available after the study has finished.
- We encourage you to talk with your whānau or family, hapu or iwi about taking part in the study.

Who pays for the study?

- You don't have to pay to take part in Take Charge - the Ministry of Social Development is funding the study.
- You won't get any payment for taking part in the study, but we may give help with transport and other costs if you need it to help you get a job.

Thank you for taking part

We'd really like to work with you, to help you get ready for and find the right kind of work for you.

Thank you for thinking about being part of our study. By taking part you'll help yourself while helping us get better at supporting other young people to get into work.

Who can I contact if I have any questions?

If you have any questions about the study, you can contact ******** from the study team at **********. If you have any questions about Take Charge, you can contact ******** from the Community Mental Health Services team on: Phone: ******* or Email: *********.

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on: Phone: 0800 555 050. Fax: 0800 2 SUPPORT (0800 2787 7678) Email: advocacy@hdc.org.nz.

If you want Māori cultural support, talk to your whānau first. Or you may contact ********** from the Community Mental Health Services team on: Phone: 03 281 7616.

This study has received ethical approval from the Health and Disability Ethics Committee (Ref 18/STH/61).

Their contact details are: Phone: 0800 4 38442 or Email: hdecs@moh.govt.nz.

Participation Consent Form
Take Charge study – Consent to take part

Please read this carefully then write and sign your name at the bottom of page two, to show you understand the aims of the study and agree to take part.

I agree that:

- I've read the participation information sheet about the Take Charge study
- I've been given the opportunity to ask questions and my questions have been answered
- I'll take part in the Ministry of Social Development's Take Charge study provided by Community Youth Mental Health Services
- Community Youth Mental Health Services can share the information below with the Ministry of Social Development, for the purpose of monitoring the service:
  - My name
  - My date of birth
  - The date I started with Take Charge
  - The date I start any voluntary work, paid work or work experience, the number of hours per week, and work address
  - The support the Employment consultant and Take Charge Co-ordinator give me to help me find work
  - The date I finish/exit Take Charge and why
  - Flexi-fund[17] payments for me
  - Other support or services that I am referred to
- I understand that my contact information may be used in the future to invite me to participate in an interview about my experience on Take Charge. I understand that I can agree to an interview or not – it is up to me
- I understand that Community Youth Mental Health Services will not share any other information that identifies me personally with anyone without my agreement, unless it is believed, in good faith, that there is a threat to the personal or public safety of myself or others
- I agree to Community Youth Mental Health Services sharing information about me, that does not identify me personally, for the study
- I understand my participation in Take Charge is voluntary

[17] A flexi-fund is available for services or products to support work outcomes, as decided by Community Youth Mental Health Services

- I understand I can withdraw from Take Charge at any time
- I would like a copy of a summary of the progress I have made and next steps agreed with me at the end of my time in Take Charge. YES/NO

Name: …….

Signature: ……. Date: ….……..