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Waitematā District Health Board
Best Care for Everyone

Implementation study of a prototype Individual Placement and Support service in Waitematā DHB

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Disclaimer

The views, opinions, findings, and recommendations expressed in this report are those of the authors. They do not necessarily reflect the views of MSD, Waitematā DHB or 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

Dr Sheryl Jury is the Clinical Director of the Health Gain Team, Funding Planning and Outcomes, Waitematā DHB and was the Delivery Lead for the implementation of the IPS prototype. Lucy Bence-Wilkins, Moira Wilson, Kecia Painuthara and Karin Henshaw are employees of the Ministry of Social Development, which funded the prototype. Helen Lockett is completing her doctorate with the University of Auckland and has extensive knowledge of Individual Placement and Support research and implementation in Aotearoa New Zealand as well as overseas. While Helen is a Strategic Advisor to Work Counts, a part of the Wise Group, she reviewed the report in her capacity as an independent researcher with subject matter expertise. Workwise is also part of the Wise Group.

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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 Aotearoa New Zealand to describe Māori concepts and names of organisations and programmes.

This glossary provides an explanation of some key Māori terms and names used in this report. Many of the definitions were advised by the Māori service in which the prototype was operating. Additional definitions were sourced from Te Aka Māori-English English-Māori Dictionary online: https://maoridictionary.co.nz/. Translations given are those most relevant to the use within this paper.

Kaumatua	Māori elders
Kaupapa Māori	A Māori approach, incorporating the knowledge, skills, attitudes and values of Māori society
Tāngata whai i te ora	Māori mental health service users
Taurawhiri	Cultural support person/advisor
Te Ātea Marino	Kaupapa Māori addictions service
Te Pae Ahurea	Specialist regional Māori Cultural Team
Ngāti Whātua	the Ngāti Whātua tribe
Tikanga	Māori customary values and practices
Whānau	Extended family, family group
Whītiki Maurea	Māori clinical service within the Waitematā District Health Board Mental Health and Addictions Division

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, 2013c).

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 intended to help. We also use the phrase 'people with mental health conditions' when we need to use language that is consistent with that used in the other studies we discuss, so that we accurately report the results of those studies.

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 terminology in this report.

We use the terms 'client', 'tāngata whai i te ora' and 'service user' when we talk about people served by the mental health teams that were part of this study. 'Participant' is the term used when we talk about the people who agreed to be part of the study.

Executive summary

Access to employment can be improved for people with serious mental illness through better integration of health and employment services.

Individual Placement and Support (IPS) is a specific, integrated approach to employment support that has been shown to be more effective than other approaches in helping people with serious mental illness find sustainable employment.

The NZ Government's 2017 Budget provided funding for the Ministry of Social Development (MSD) to purchase an IPS service for up to 500 people over four years, for 18-35 year olds, to be delivered by Adult Mental Health Services at Waitematā District Health Board (DHB).

This report presents findings from an implementation study of a nine-month prototype of the service that began in 2018.

The study

A requirement of the 2017 Budget process was that this initiative be evaluated while it was being implemented. The evaluation would focus on understanding and demonstrating effectiveness in improving outcomes. In line with this requirement, a staged mixed-methods study is being undertaken.

The prototype stage and associated implementation study was designed to assess programme reach, retention, activities and outcomes, and sought to understand the cultural fit of the IPS service and provide learnings from the implementation that could inform the main trial. It also assessed the level of adherence to the evidence-based practices and principles of IPS. This is known as *programme fidelity*.

Activities included collection of de-identified monitoring data, interviews with staff involved in the planning and delivery of the prototype, and an independent review of fidelity to IPS principles and practices. The prototype stage was not intended to assess the impact of the service on employment or other outcomes for participants.

The prototype

The employment team for the IPS prototype comprised two experienced Employment Consultants and one part-time IPS supervisor (who provided expertise or 'technical assistance') from an established employment support service provider with experience of implementing IPS programmes.

This team was integrated with two Waitematā DHB Mental Health Teams – the West Auckland Adult Community Mental Health Service and the Henderson site of the Moko (Māori Mental Health) Service. Relationships were established with the local Work and Income (W&I) Service Centre and regional staff. The employment team began accepting referrals from the mental health teams in June 2018.

Participants

Those eligible for referral were clients aged 18-35 who said they wanted to work but were unemployed, at risk of losing their employment, or were receiving a main benefit. Under the contract with MSD, 80 percent of available places were reserved for people receiving benefits. Clients aged 36 years and older were offered existing employment support services.

By the end of the prototype recruitment period, 92 people had been referred to the IPS team, and 50 had agreed to join the study. Twenty-five participants were Māori, and 40

out of 50 participants reported being supported by a benefit. Most had been out of work for a year or more. Just over half (28, or 56 percent) had a diagnosis associated with psychosis (schizophrenia, psychotic disorder or drug-induced psychosis).

Of the 50 participants, 43 were able to be followed for a full three months from entry when study data were collected at the end of December and 32 remained in the service at the three-month mark. Sixteen participants (37 percent) found work within this time, and for 13 of these participants that work was full-time (30 or more hours per week). These results were encouraging when compared to employment outcome benchmarks from international studies.

Success factors

The prototype was successful in achieving a high level of integration between employment services and clinical support services.

Staff interviewed identified the following factors that combined to contribute to the success of the prototype:

- credible and proactive leadership within each of the project partners and the Steering Group,
- the positive and eager attitude of the mental health teams, and
- the technical expertise and implementation support from the employment service provider.

Additionally, the immediately noticeable benefits of the service – such as the ease of referrals, the direct and ongoing contact between clinical, Work & Income and employment service staff, and the early successful outcomes of the service – led to significant support from the clinical teams.

The robustness of the IPS approach to employment support and the health-led implementation of the prototype were also considered important success factors.

Clinician experience of the prototype

Clinician perceptions of the programme, and of changes in people who received IPS, were overwhelmingly positive. The introduction of IPS, and the focus on employment as a health intervention, positively impacted on the culture of the mental health teams. It created a more holistic understanding of the health and wellbeing of service users and an increased focus on their strengths, and on supporting their employment aspirations.

Cultural responsiveness for Māori

Interviews with staff, including clinical staff in Moko Services, suggest that the IPS practices and principles align well with a kaupapa Māori approach to mental health service delivery, and that the service was experienced positively by Māori participants.

However, some conflicts with a kaupapa Māori approach arose during the implementation process. Limited consultation in implementation, driven in part by the short lead-in time, conflicted with the kaupapa of the Moko Service. The restricted age and location criteria and the short-term nature of the prototype were also criticised for conflicting with the relationship-based approach of Moko Services.

Additional cultural components needed to be considered in implementation and allowed for in timelines and resourcing. Staff also pointed to the need for workforce development to support the cultural capability of staff delivering employment support.

Barriers, and learnings from the prototype

Elements of the implementation were difficult, particularly in the early stages. Most of the difficulties related to the short timeframe between the conclusion of contract negotiations and the go-live date. Planning for the study, ethical review, and contract negotiations needed to be mostly completed before implementation could begin. Delays associated with these processes and the requirement to spend the funding within a set timeframe, meant the lead-in time between concluding contract negotiations and the go-live date was very short. This limited the time available the mental health teams to prepare for the service.

While the IPS practices and principles were well received by the clinical teams, there was widespread discomfort among staff involved in delivering the service with limiting access to the service to 18-35 year olds. The teams had both ethical and practical issues with this aspect of the service.

Fidelity to IPS principles and practices

Fidelity reviews examine the practices and principles adopted by both the mental health teams and the employment support service, and the way in which these services work together. They are used as a developmental tool to help improve IPS service quality. As part of the study of the prototype, an independent reviewer conducted a fidelity review five months after the service began and provided recommendations for improving observance of IPS principles and practices.

Fidelity reviews score services out of 125, and give a rating to indicate the level of fidelity achieved. The prototype was scored at **97/125** giving it a rating at the upper end of 'Fair Fidelity', and close to the 100-point threshold for being considered 'Good Fidelity'. 'Fair Fidelity' is a common baseline assessment for a new IPS implementation.

The fidelity reviewer commended the success of the prototype in implementing many elements of IPS in a short period. The prototype achieved full implementation of items related to integration, the roles of the employment consultants, and the type and diversity of employment.

IPS practices and principles that were less successfully implemented and recommended by the reviewer as areas for immediate focus over the coming 12 months were as follows.

- 'Agency focus on competitive employment' such that competitive work is promoted through multiple strategies in the mental health services – recommendations included reminders for mental health practitioners to discuss employment aspirations, experiences, and interests with clients.
- 'Zero exclusion' so that all clients served by the mental health team interested in working have access – recommendations included educating mental health practitioners on the importance of zero exclusion, and the role of employment as part of recovery. While the age restriction was not taken into account by the fidelity review (because it was not under the control of the teams delivering the service), the reviewer noted that this aspect of the service did not support the 'zero exclusion' principle.
- 'Time-unlimited follow-along in-work supports' – recommendations included more regular, face-to-face support for those in jobs.
- 'Community-based services' – recommendations included increasing the amount of time spent providing employment services in community settings and visiting employers to learn about their hiring preferences.

Recommendations

Based on the implementation study of the prototype, the following recommendations were made for the main trial at Waitematā DHB:

- **Remove age limits on eligibility.** The age limit was not supported by the mental health teams and was challenging to implement. The findings also suggest that the contractual requirement to reserve 80 percent of participant places for benefit recipients was not required.
- **Give attention to cultural responsiveness in both service delivery and implementation approaches.** The study confirmed that time is required for engagement and for honouring cultural protocols and this should be considered when funders and DHBs plan for IPS implementation. It will be important to build a workforce with cultural capacity if IPS is taken to scale. More research on ways to ensure cultural responsiveness of IPS in the Aotearoa New Zealand context would be beneficial.
- **Resource technical assistance, implementation support, and independent fidelity reviews.** Findings from this study highlight the important role that on-site technical assistance and independent fidelity reviews by experienced people can play in promoting the quality and effectiveness of IPS implementation. These will be useful elements to retain as new providers are contracted to deliver the main trial, and additional mental health teams gain access to the service. Mechanisms for embedding fidelity reviews and technical assistance should be considered in any future national scaling-up of IPS. These can be provided independently of the employment support.
- **Carefully consider whether contracting for outcomes is appropriate, and the impact contracting arrangements have on service delivery**. Contracting for employment outcomes may not be appropriate when services need to balance employment with mental health goals. An alternative could be to contract for services that are aligned with evidence-based practices and principles, along with best practice for cultural responsiveness. In any future scaling-up, longer-term contracts would support relationship building with mental health teams, and make it easier for them to plan for and support IPS delivery. The study highlighted a need for contractual timelines that allow for greater consultation with clinical teams in the planning phase, and more time for the clinical teams to prepare for integrating employment support services.
- **Refine the role of Work & Income staff to ensure access to benefits information.** The support of nominated staff from local W&I sites was regarded as highly beneficial to service users by the employment service provider and clinical teams. Collaboration with W&I is an important part of high-fidelity IPS services, and the prototype scored highly for its collaboration with W&I. However, the findings from the interviews indicate that W&I staff could provide more relevant support, including better access to information about benefit entitlements, and benefit counselling to work through different employment scenarios. The designated contact people – Programme Coordinators – did not have access to detailed benefits information as this is held by W&I case managers. The limited access to benefits counselling was noted in the fidelity review.
- **Find a more effective method of collecting participant feedback.** Surveys were not an effective tool for gathering feedback from the people participating in the prototype and other options should be explored.

Conclusion and next steps

The IPS prototype at Waitematā DHB is a significant achievement. It was implemented with no major problems and was experienced positively by clinical teams. It achieved an impressive level of fidelity to IPS practices and principles in a short time and was perceived to have benefits for participants.

Based on success in the prototype, the main trial of the Waitematā initiative will proceed.

The main trial will expand access to IPS to clients throughout the DHB's Adult Community Health Teams without any restrictions around age or benefit receipt. Learnings from the prototype will inform the next stage.

Future research activities will include a Māori-centred study to explore how Māori service users experience IPS and the way in which the service is successfully adapted by Māori mental health and mainstream teams. This study will help funders, providers, IPS teams and fidelity reviewers incorporate Māori culture in the delivery of IPS. This study could be followed by work to consider how cultural adaptations can be made to meet the needs of Pacific and other ethnic groups. Other activities will include an impact evaluation using an observational quasi-experimental design, together with further fidelity reviews, and continued programme monitoring.

The 2018 OECD country report *Mental Health and Work: New Zealand* (OECD, 2018) recommended expanding evidence-based integrated health and employment support services to ensure national coverage. The Waitematā DHB experience offers useful lessons for other initial implementations, and for possible future expansion.

1. Introduction

In the NZ Government 2017 Budget, funding was provided for MSD to purchase up to 500 Individual Placement and Support (IPS) places over four years, to be delivered within the Waitematā District Health Board's (DHB's) mental health teams. Treasury released the funding contingent on approval of a high-level plan for a study focussed on understanding and demonstrating the effectiveness of IPS.

This study of IPS is part of a programme of work expected to inform decisions by government about whether/how to expand IPS. The programme of work aims to strengthen the evidence of effectiveness for Māori clients, in particular. This is important given the over-representation of Māori in the target population. If IPS is found to be effective for and acceptable to Māori and the decision is made to expand the service, improvements in socio-economic and health status for Māori, and reductions in disparities in these outcomes may result.

The first stage involved establishing a small IPS prototype and an implementation study. The aim was to assess whether the initiative was operating as intended before the main trial started, and to provide feedback on the processes and practices that worked well and flag areas where there were opportunities for improvement. This report draws together those findings.

Report outline

The report begins with background information on IPS, the Waitematā IPS initiative, and the implementation study design (Section 2), and a description of the prototype (Section 3), before exploring the following questions:

- **Programme reach, retention, activities and outcomes in the short term** (Section 4): What was the rate of take-up of the IPS prototype by those referred? What were the characteristics of participants and what proportion were supported by benefits? How many people exited the service and why did people leave? What were the activities and employment outcomes for participants in the very short period of the prototype?
- **Overall views on the prototype and key success factors** (Section 5): Was the prototype experienced as helpful by the mental health teams? What were their perceptions of changes for participants? What went well and what supported the success of the prototype?
- **Cultural acceptability and responsiveness for Māori** (Section 6): Did insights gathered suggest a need for changes to the IPS approach or its implementation to improve cultural acceptability and relevance? What changes, if any, need to be made in the main trial?
- **Other implementation barriers, and learnings** (Section 7): What was challenging in the implementation of the prototype? Were there learnings that could inform the main trial?
- **Fidelity** (Section 8): Did the prototype of the initiative have good fidelity to IPS principles and practices as intended? What are the changes that could be made to improve fidelity?

Section 9 outlines the limitations of the prototype and the implementation study. Section 10 discusses the findings and recommendations for the trial. Section 11 concludes and sets out next steps for the study.

2. Background

In this report we use the phrase 'people with serious mental illness', as it is important to be clear about the population served by this IPS implementation, to enable comparison with similar implementations. However, we recognise that people are people first, with employment aspirations and desires, and are not defined by their illness. Many people living with serious mental illness want to work but cannot find jobs. In OECD countries, unemployment rates among people diagnosed with serious mental illnesses (which include low prevalence, high impact conditions such as schizophrenia, schizoaffective disorders, and bipolar affective disorders) are four times higher than those for people with no disorder (OECD, 2018).

Data limitations make it difficult to estimate the number and proportion of New Zealanders with serious mental illness who want to work (Lockett, Waghorn, & Kydd, 2018b). However, a 2010 Australian national survey of people affected by high impact psychosis is informative. Only 33 percent of respondents to that survey had been in paid work over the course of a year, and 85 percent relied on a government benefit for their main source of income. Participants were asked to name the top three challenges they faced in the coming year. Lack of employment was reported by a third of respondents overall, and by 45 percent of respondents aged 18-34 years. This was the top-ranked challenge for the younger age group, and the third-ranked challenge for respondents overall (Morgan et al., 2017). In a smaller survey of Australians living with schizophrenia, interest in employment was high, with 85 percent of participants being either employed or interested in employment as a future goal (Westcott, Waghorn, McLean, Statham, & Mowry, 2015).

In an OECD analysis of the 2016/17 New Zealand Health Survey, half of New Zealanders receiving a main working-age welfare benefit have a mental health condition based on K10 scores (OECD, 2018, Box 1.1 & Figure 1.3).[1] Close to one in five of those receiving a Supported Living Payment or Jobseeker Support[2] have a condition classed as severe using the K10 scores, as do one in ten of those receiving Sole Parent Support[3] (OECD, 2018, Figure 1.3). The risk of poverty for New Zealanders with mental health conditions is comparatively high, especially for those with severe conditions (OECD, 2018).

People with low educational attainment and those who identify as Māori or Pacific are more likely to be affected by mental health conditions than other population groups, and have a larger employment disadvantage when they also have a mental health condition (OECD, 2018). These population groups are over-represented among people supported by health-related benefits.[4]

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[1] For the purposes of this analysis, the OECD used the Kessler Psychological Distress Scale (K10) to identify mental health status and drew on consistent findings from epidemiological research to classify the 20 percent of the population with the highest values as having a mental disorder in a clinical sense. The top five percent of values denote "severe" conditions and the remaining 15 percent indicate "mild-to-moderate" or "common" conditions.

[2] Prior to the 2013 Welfare Reform, Supported Living Payment was Invalid's Benefit, and Jobseeker Support was Unemployment Benefit and Sickness Benefit. Due to benefit transfers associated with changes to age-of-child eligibility criteria and work obligations for other benefits, these benefits now also provide for some people who would have formerly been supported by Domestic Purposes and Widow's Benefits.

[3] Formerly Domestic Purposes Benefit, with changes to age-of-child eligibility criteria and work obligations.

[4] Ministry of Social Develoment. Unpublished tables.

The 2016 New Zealand Heath Strategy includes a set of principles to guide health sector development. These include acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi. Article 3 of the Treaty provides for equal rights for Māori and non-Māori. Inequalities in health, employment and benefit receipt, need to be eliminated. In Waitematā, the DHB, Te Rūnga o Ngāti Whātua and Te Whānau o Waipareira are working together to improve the DHB's capacity to deliver health care to Māori (Waitemata District Health Board, 2017).

International evidence shows that access to employment can be improved for people with serious mental illness through better integration of health and employment services. Co-ordination of employment with mental health treatment and care is important because while work 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). Expanding access to evidence-based integrated approaches has been recommended in a series of reports, most recently the 2018 OECD country report *Mental Health and Work: New Zealand* (OECD, 2018).

The IPS approach

IPS is an internationally-used, evidence-based integrated approach to employment support for people with serious mental illness and people with addiction (particularly alcohol and drug dependence). The approach is based upon eight principles and practices (Becker, Swanson, Reese, Bond, & Mcleman, 2015; Bond, Drake, & Becker, 2012).

- **Integration of mental health and employment services**: IPS involves Employment Specialists or Employment Consultants co-locating and working closely with a publicly-funded specialist mental health or addiction treatment team. Together the teams provide an integrated approach to assisting people under the care of the clinical team to gain and maintain employment. Referrals to the Employment Consultant come from no more than two mental health treatment teams.
- **Focus on competitive employment**: employment in mainstream competitive jobs, either part-time or full-time, is the primary goal, ie jobs paying the minimum wage or above and jobs not reserved for people with a health condition or disability.
- **Eligibility based on client choice – 'zero exclusion':** everyone under the care of the mental health or addiction team who is interested in working is eligible for employment support regardless of, for example, job-readiness, past or current substance use, mental health symptoms, past behaviours, cognitive impairments, legal system involvement or personal presentation.
- **Attention to client preferences:** job search is consistent with individual preferences, and services are based on each person's preferences and choices, rather than the Employment Consultant's or clinician's judgements.
- **Rapid job search:** people are helped to look for jobs soon after entering the programme (within four weeks) instead of being required to participate in pre-employment activities such as training, intermediate work experience, vocational assessments, or sheltered employment. Appropriate training and support is then offered once a participant secures a job.
- **Systematic job development:** Employment Consultants develop relationships with employers and seek work opportunities based on a person's work preferences.
- **Time-unlimited and individualised job supports**: Employment Consultants have low caseloads (an active caseload of 20 people is recommended) and support is individualised to both the employer and the employee; job supports

continue for as long as each worker wants and needs the support; some people are supported in several jobs before finding sustained employment.

- **Work incentives planning:** benefits counselling, including advice on how working will affect benefits, supports the person to transition from benefits to work.

IPS has been shown to be effective in improving vocational outcomes for adults with serious mental illness. Randomised controlled trials (RCTs) conducted in a range of jurisdictions show around twice as many IPS participants obtain employment, compared to clients who receive other types of vocational assistance (Drake & Bond, 2014), and that IPS is effective for people with a variety of serious mental health diagnoses, educational levels, and prior work histories; and for people with co-occurring mental illness and substance use disorders (Bond & Drake, 2014; Campbell, Bond, & Drake, 2011).

In reviews, systematic reviews and meta-analyses (eg Modini et al., 2016; Lockett, Waghorn, Kydd, & Chant, 2016; Frederick & VanderWeele, 2019; Marshall et al., 2014; Bond et al., 2012), including a Cochrane review (Kinoshita et al., 2013), IPS has consistently demonstrated significantly more effectiveness 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. In a recent meta-analysis of supported employment programmes, including IPS, the pooled competitive employment rate for participants was 50 percent (95 percent CI 43–56 percent) from RCTs, and 43 percent (95 percent CI 37–50 percent) from routine programmes implemented without an RCT (Richter & Hoffmann, 2018).

A number of studies point to the importance of close attention to implementation, as measured by IPS fidelity (Bond, Drake, & Becker, 2012; Bonfils, Hansen, Dalum, & Eplov, 2017; Lockett et al., 2016; Gilbert & Papworth, 2017). Programme fidelity assessed using a validated and standardised scale has been found to have a moderate, yet important, role in predicting employment outcomes. However good programme fidelity is necessary, but not sufficient, for good outcomes (Lockett et al., 2016). Other aspects of implementation quality and factors not currently captured by fidelity scales may also be important. These include technical support for implementation, ongoing programme evaluation, Employment Consultant expertise, and aspects of programme intensity (Lockett, Waghorn, & Kydd, 2018a).

There are, however, a number of evidence gaps. There is little evidence internationally on the effectiveness of IPS for different ethnic groups and for indigenous people, or on cultural adaptations that could enhance engagement and effectiveness (Marshall et al., 2014; Closing the Gap Clearinghouse, 2014). Lower effectiveness has been observed for implementations outside the United States. This suggests different mental health, social security and welfare benefit systems and different employment and regulatory contexts may moderate the outcomes of IPS. More research is needed to determine what adaptations are needed in different contexts and with different populations (Bond et al., 2012; Lockett et al., 2018a). Evidence on augmentations (eg cognitive therapy and psychosocial skills training) that can improve programme effectiveness is still emerging (Dewa et al., 2018).

There is comparatively little evidence on non-vocational outcomes, including measures of wellbeing and cost effectiveness (Frederick & VanderWeele, 2019; Kinoshita et al., 2013). In a recent meta-analysis, there was some evidence that IPS may improve quality of life and maybe 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). In an Australian study that compared cohorts before and after shifting from standard services to good fidelity IPS practices, IPS involved higher total costs per participant, but standard services were less effective and less cost effective than IPS per employment outcome attained (Parletta & Waghorn, 2016).

IPS in Aotearoa New Zealand

IPS services have been operating in Aotearoa New Zealand for over a decade but are not widely available. In 2017, seven out of 20 DHBs offered IPS, and two more (including Waitematā DHB) were due to begin offering IPS. Where IPS was operating, it was not accessible to everyone under the care of mental health services (Lockett, Waghorn, & Kydd, 2018b). In regions where IPS is not available, there are other forms of supported employment that people with a mental health conditions can access. These have some features in common with IPS (Te Pou, 2015), but do not offer employment support integrated with mental health treatment and care (Lockett et al., 2018b).

Several of the early IPS implementations were funded through contracts with MSD. In one of these implementations, MSD funding supported the expansion of a Capital & Coast DHB early intervention psychosis team for youth initiative, which had started in 2001 (Porteous & Waghorn, 2007; 2009). Other MSD-funded early implementations were delivered by Workwise, an NGO specialising in employment support services, and followed an 'attachment model' where Workwise employment staff were linked with DHB mental health teams but clinical and employment services were not fully integrated (Browne, Stephenson, Wright, & Waghorn, 2009; Waghorn, Stephenson, & Browne, 2011). Another early IPS implementation involved an attachment model partnership between the Waikato DHB and Workwise, funded by the DHB (McLaren, Kristensen, & Li, 2005, in Porteous & Waghorn, 2009).

Despite less than full integration in some cases, several studies of early implementations showed good programme fidelity was achieved. They also showed encouraging employment outcomes when compared to international benchmarks from IPS RCTs, including positive outcomes for Māori. However, in some cases contractual limitations on referral criteria meant these implementations did not reach large numbers of people with psychotic disorders, the group facing multiple barriers to participating in the labour market (Priest & Lockett, in press; Morgan et al., 2017).

Although MSD funding for the early implementations was discontinued, the success of these early initiatives led to a number of DHBs funding IPS services with varying degrees of integration, and at varying scales. Interest in applying IPS principles within primary care also grew and pilots and evaluations were funded by W&I (Te Pou, 2013a; Te Pou, 2013b), but primary care initiatives have not been funded on a sustained basis.

In 2015, implementation support for IPS was piloted in existing services operating in Counties Manukau and Auckland DHBs. Technical assistance provided by a dedicated implementation manager was found to improve fidelity with IPS principles and practices (Kongs-Taylor & Lockett, 2017). Following this pilot, and informed by growing international recognition of the importance of technical assistance for improving effectiveness, an NGO centre of expertise for IPS, Work Counts, was established. In 2017 Aotearoa New Zealand also joined the International IPS Learning Community, and a national IPS Steering Group with representatives across MSD and the Ministry of Health was established (Priest & Lockett, in press).

In a very recent initiative, Northland DHB received funding through Proceeds of Crime monies in 2017 to set up an IPS pilot as part of an initiative to reduce methamphetamine

demand by enhancing clinical treatment in combination with employment support. This initiative built on lessons learnt from earlier IPS implementations and included:

- technical assistance and independent fidelity reviews
- full integration of clinical and employment services
- a contract that supported unrestricted referral criteria and
- explicit attention to cultural responsiveness and addressing inequities for Māori.

The programme is achieving good engagement and outcomes for Māori against a backdrop of high levels of labour market marginalisation and other disadvantages among participants (Priest & Lockett, in press).

To date there has been no rigorous impact study of IPS in the Aotearoa New Zealand context and this has been one of the barriers to making IPS more widely available. The present study is part of a programme of work that aims to help address this gap.

The 2018 Waitematā IPS initiative

In 2016, the Waitematā DHB developed a proposal for a four-year project which included an employment support service aligned with IPS principles and practices, and other services for people with serious mental health conditions. The project aimed to increase employment and enhance financial independence, improve mental and physical health, and reduce socio-economic, physical and mental health disparities for Māori. The proposed project was targeted at 18-35 year olds who were either supported by benefit, or who were not working or in education, as they were likely to accrue the longest duration of improvements in wellbeing. The proposal was for an initial small pilot as part of a phased implementation to help inform the final design, and a non-randomised trial that would assess impacts using quasi-experimental methods[5] (Robinson, Jury, McKenzie, Patton, & Rygate, 2016).

In late 2016 and early 2017, MSD and the Waitematā DHB worked together to seek funding for a modified version of this initiative[6] through the Government's 2017 Budget. This bid was successful, and funding was provided for MSD to purchase up to 500 IPS places over four years.

Alongside the Waitematā DHB initiative, funding was also secured for an IPS trial for young people supported by benefit in Christchurch. This initiative was intended to be based on IPS principles, but was adapted in a number of ways to meet the needs of the target group (Wilson, Painuthara, Henshaw, & Conlon, 2019).

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

[5] The option of assessing impacts using a randomised controlled trial (RCT) was rejected. Ethical justification for an RCT would require genuine uncertainty about whether IPS or usual services would provide more benefit to clients. Existing evidence suggests that IPS implemented with high fidelity improves movement into employment across a range of contexts and results in modest improvements in quality of life.

[6] Peer support workers and provision for referral from GPs and W&I and provision for physical health support via primary care, for example, were included in the initial proposal but not in the Budget bid.

The initial stage for the Waitematā initiative was to establish and evaluate a small prototype IPS service. The aim was to assess programme fidelity, reach and retention, activities and outcomes, and cultural fit, and to provide implementation and other learnings for the main trial.[7]

Methods

Implemetation study methods included collection and analysis of de-identified monitoring data, and interviews with a range of staff members involved in the planning, implementation and delivery of the prototype. More detail about the methods used for the staff interviews is explained in Box 1.

Box 1: Staff interviews

Those interviewed included clinical staff in mental health teams, staff from the DHB leadership, planning and funding teams, the MSD service design team, local W&I staff, and employment support team members. The interviews were semi-structured, so that the same question themes were covered in each interview but with scope to adapt questions to the interviewee (based on their role in the prototype), and to explore key points raised by interviewees in more detail.

In total, 13 interviews were conducted with a total of 19 participants. The majority of interviews were face-to-face and a small number were conducted by telephone. The interviews were conducted by two researchers from Insights MSD. Both researchers were present at all but one of the interviews. With both researchers present, one researcher led the interview while the other took detailed notes. For the one interview where only one researcher was present, notes were taken and the main points were then confirmed verbally with the interviewee. It was decided not to record the interviews due to time restrictions, and because an in-depth narrative analysis was not part of the methodology.

The researchers, individually and then together, analysed the interview notes to identify recurring points made by multiple interviewees. These were coded and categorised according to their relationship to the main research questions, and in doing so common themes emerged. Where clarification was required, the researchers contacted the interview participants. Initial findings were shared with the MSD service design team and the Waitematā IPS steering group for feedback and confirmation.

Following the interviews, the mental health teams were asked to provide some background information about their services for inclusion in this report. Relevant information has been added, with their consent, to the findings section of this report.

As part of the study, an independent fidelity review was undertaken using the IPS-25 Fidelity Scale (Becker, Swanson, Bond, & Merrens, 2011). The review was conducted by Sandy Reese, an experienced IPS supervisor and trainer from the IPS Employment Centre at the Rockville Institute in the United States.[8] This review (Reese, 2019) involved interviews with staff involved in delivering the prototype, as well as observations, document review and interviews with four prototype participants. Researchers from Insights MSD observed most of the fidelity review interviews in order to understand the process and to avoid duplicating questions in the staff interviews. This ensured that the scope of the fidelity review and staff interviews was kept distinct.

[7] Feasibility studies do not evaluate the impact of the intervention on the outcome of interest - that is left to the main study (Arain et al., 2010).

[8] This was to mitigate the potental for conflict of interest if a Work Counts assessor had undertaken the review.

An anonymous client satisfaction survey was undertaken in an effort to assess the acceptability of the prototype, including its cultural acceptability, and to gain insights into the work aspirations of participants[9]. However, the number of surveys returned was too small for results to be included in the analysis. The low response rate indicated that this method of collecting client feedback is not effective, and options for more suitable methods will be considered during the design of the trial phase.

Anonymous client stories have been included in this report with the consent of the individuals concerned. These stories were prepared by Workwise Employment Consultants in collaboration with participants for MSD.

Like other implementation studies (eg Porteous & Waghorn, 2007; 2009; Browne, Stephenson, Wright, & Waghorn, 2009; Waghorn, Stephenson, & Browne, 2011), members of the research team included a staff member involved in programme delivery. Their involvement provided insights into the 'on the ground' operation of the prototype, from a staff perspective.

Ethics approval was granted by the Southern Health and Disability Committee (Ethics Ref 18/Sth/57).

[9] Questions asked were modified versions of questions in the Health Quality and Safety Commission Primary Care Patient Experience Survey, and questions used in other Aotearoa New Zealand studies that have sought participant feedback on cultural acceptability.

3. The prototype

Contracting

In early 2018, MSD and Waitematā DHB agreed a contract for delivery of an ISP prototype involving 50 participants. The contract set out performance and data requirements (for MSD contract monitoring), and requirements for provision of de-identified data (for the implementation study).

This contract made no provision for further funding. MSD's intention was that contracting for the main trial would be contingent on a successful prototype. The prototype was to run for nine months, beginning in June 2018. The desirability of maintaining the flow of referrals so as not to break service momentum was quickly recognised, and based on early indications of success a contract extension was agreed in December 2018 to allow this to happen.

Time required for planning and securing ethical approval for the study, and for contract negotiation was longer than anticipated. This meant the lead-in time from the conclusion of contract negotiations (1 May 2018) to the go-live date (5 June 2018) was very short, and, although initial discussions with mental health teams and relevant Governance and Steering Groups had begun in early 2018, staff in the mental health teams had limited time to prepare for the service.

Waitematā DHB had planned to conduct an open tender process to select service providers for the IPS initiative from its inception. However given its research focus, the decision to prototype, compressed time frames, and the absence of any guarantee on future funding, an exemption was sought. Workwise, an employment support service provider which was delivering IPS services for the neighbouring Auckland DHB, was engaged to deliver employment services for the prototype. Should the main trial proceed, it is intended that an open Government tender process be undertaken to select the employment support service providers.

Establishment

The prototype began operation in the Henderson site of the Moko Services (Māori Mental Health) and the West Auckland Adult Community Mental Health Service (ACMHS) on 5 June 2018 (see boxes 2 and 3 for a description of these services). These services together serve approximately 1000 clients, of whom 40 percent are between the ages of 18-35. West Auckland ACMHS had approximately 330 people in the 18-35 age group and Moko Service approximately 60 people. The teams were chosen as the sites for the prototype because they are in areas of high need, and because of their positive responses to the invitation to participate.

The employment team met weekly to review caseloads, new referrals, exits or declines to the programme, new employer contacts, outcomes, and attempts to re-engage clients. They also discussed solutions to barriers to employment for individual clients. One Employment Consultant worked with Moko Services and the other with West Auckland ACMHS. They did not provide coverage for each other's clients, however the supervisor was able to cover for the Employment Consultants during their absences.

Box 2: Moko Services

Moko Services is one of three teams in Whītiki Maurea, the Waitematā DHB's Māori mental health and addiction services: Moko Services (Mental Health), Te Ātea Marino (Addictions Service) and Te Pae Ahurea (Cultural Advisor Team). Whītiki Maurea is committed to delivering holistic services to tāngata whai i te ora (service users). This is accomplished by weaving together Māori cultural values and Western clinical practice, thereby ensuring tāngata whai i te ora and their whānau are supported to achieve the best possible health outcomes.

Moko Services provides Māori kaupapa-based specialist mental health services working towards recovery for adults aged 18 to 65 years of age who live in the Waitematā DHB area. The multidisciplinary team includes specialists in psychiatry, psychology, nursing, social work, cultural advisory and occupational therapy, who work together to provide assessment and intervention. The service is based in Henderson and Takapuna but are also delivered in other community locations in order to meet the needs of tāngata whai i te ora.

A key component of Whītiki Maurea service delivery is employment of two Kaumatua (Māori elders) and Te Pae Ahurea (Cultural Advisor team). The Kaumatua provide cultural oversight and strategic support and advice for the entire service. Te Pae Ahurea provides the specialist Māori cultural elements that stem from a Māori worldview. These cultural elements include:

- fulfilling cultural protocols
- completing cultural appraisals on tāngata whai i te ora
- cultural interventions
- facilitating culturally-based programmes.

Te Pae Ahurea staff work across Moko Services and Te Ātea Marino, as well as providing specialist Māori cultural input in the inpatient units and for all teams within Specialist Mental Health and Addictions Services. Whītiki Maurea receives referrals from Specialist Mental Health and Addictions Services, Māori non-government organisations, whānau, Corrections Services (Probation), schools and from the community. It primarily delivers community-based care providing outpatient appointments, and employs approximately 50 full-time equivalent staff (FTEs) across the service, with 14 FTE based in Moko Services. Staff may have dual competencies, eg cultural and clinical.

Box 3: West Auckland Adult Community Mental Health Service

The West Auckland Adult Community Mental Health Service provides ongoing and crisis support for adults aged 18-65 years who live in the Waitakere City Boundary. The service works alongside the person and their family or whānau to provide treatments that will help the person to recover from mental illness. These may be medications and/or talking therapies. Staff working in mental health services aim to support and empower people on their recovery journey and come from a range of disciplines including psychology, occupational therapy, social work and medicine (psychiatrists, mental health specialist nurses) along with consumer advisors and cultural support workers.

West Auckland ACMHS encompasses:

- community-based outpatient services (the prototype was based with these teams)
- emergency and crisis assessment
- in-patient treatment
- alternatives to in-patient treatment (crisis respite care and home-based crisis support)
- access to specialist ongoing rehabilitation and extended care residential facilities.

Those whose primary needs relate to alcohol and/or drug problems, or who have a dual diagnosis, are served by a separate service line within the DHB – Community Alcohol and Drug Services.

Relationships were established with the local W&I Service Centre and regional staff. The Service Centre manager was actively involved in the design and monitoring of the prototype. Two W&I programme coordinators were involved in the delivery of the prototype. Within W&I, the role of a Programme Coordinator is to work with contracted employment service providers to promote and facilitate referrals into a service, and keep track of client participation and outcomes. The programme coordinators involved in the IPS prototype worked closely with the IPS employment team to help clients with their employment and education goals, using W&I Transition to Work Grants to fund items needed to support a person to secure or maintain employment.

The IPS team comprised two Employment Consultants and one part-time IPS supervisor who also provided technical assistance and implementation support, with back-up support from Workwise business support and leadership. There was no dedicated implementation manager role. Given the short lead-in time, these staff members were seconded from other roles, but all had previous experience in delivering IPS ranging from one to more than 10 years.

As the prototype was getting underway, the Aotearoa New Zealand economy was characterised by low inflation and low unemployment (4.4 percent in the June 2018 quarter).[10] Annual growth in Gross Domestic Product at the time was 3 percent.[11]

Governance

The Waitematā DHB IPS prototype was one of a group of initiatives overseen by the Oranga Mahi Board chaired by Professor Des Gorman from the University of Auckland. A local Waitematā DHB steering group was established to oversee and support the implementation and study. The steering group comprised a consumer representative, clinical leads and staff from West Auckland ACMHS and Moko Services, representatives from the DHB's Planning, Funding and Outcomes group, and Workwise staff. The group met monthly from May 2018. Considerable 'in-kind' organisational and staff-time support for the implementation and study not covered by Budget 2017 funding was provided by Waitematā DHB, MSD, and Workwise.

Recruitment of participants

Recruitment and consent to participate in the study occurred as part of normal mental health service delivery. Those eligible for referral were clients aged 18-35 served by the two teams who said they wanted to work and were unemployed, who were at risk of losing their employment or who were receiving a main benefit. Clients not receiving an MSD benefit were not excluded from participation, but under the contract with MSD 80 percent of the available places were reserved for those receiving a benefit. Clients aged 36 years of age and older were offered existing employment support services.

Clients invited to participate in the study were given a study Information Sheet and Consent Form (attached as an Appendix), an information sheet about IPS, and "Your

[10] See Labour market statistics: September 2018 quarter | Stats NZ.

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

Rights When Receiving a Service" and "Code of Rights" brochures. The service was described as "Individualised Employment Support". The study Information Sheet and Consent were reviewed by consumer advocates. Workwise Employment Consultants administered a separate participation and data collection and sharing consent process. Participation was free and voluntary and participants were able to withdraw at any point.

Services provided

In line with the IPS approach, services were tailored to the individual. Employment Consultants worked closely with participants to identify their employment goals and develop an individualised employment plan to guide the job search process. Employment plans were coordinated with clinical plans. The Employment Consultants supported participants to identify their skills and work preferences, identify potential employers and approach them (they either did this on behalf of the participant, or supported the participant to do so). They also provided help with job applications and interviews. Once in work, the Employment Consultants provided individualised support to help the participant transition into, and maintain, their employment. Employment Consultants could also help the client access additional health treatment from the clinical teams during the transition into employment and while working.

4. Reach, retention, activities and outcomes in the short term

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

Numbers referred, and the proportion who consented to participate

A total of 92 people were referred to the IPS employment support service up to the point where 50 people had consented to take part. The conversion rate (the proportion of referrals where the person went on to consent to participate in the prototype) was 54 percent.

Table 1: People referred and people consenting to participate in the prototype

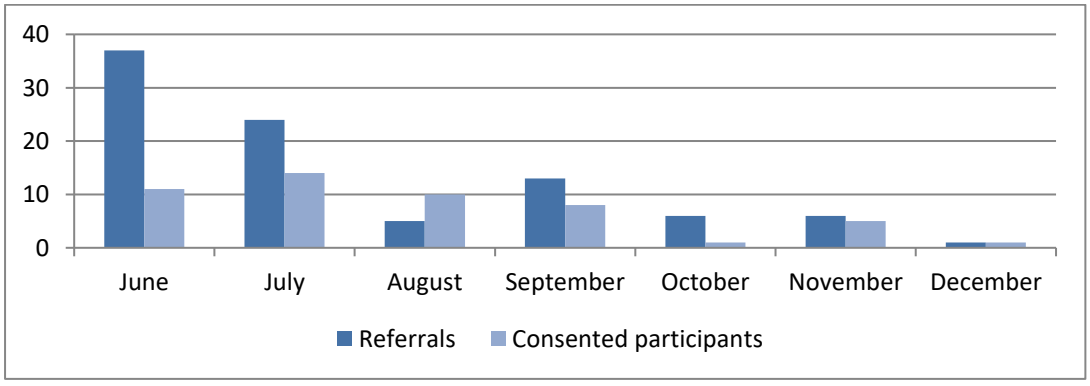
		Total referrals	% Total referrals	Total referrals consented	Conversion rate
Referring team	ACMHS	58	63%	30	52%
	Moko Services	34	37%	20	59%
Gender	Male	56	61%	31	55%
	Female	36	39%	19	53%
Ethnic group	Māori	46	50%	25	54%
	Non-Māori	46	50%	25	54%
Total		92	100%	50	54%

The West Auckland ACMHS has approximately 840 clients in total and Moko Services serve approximately 175 people (this figure also includes tāngata whai i te ora outside the Moko Services West catchment). The West Auckland ACMHS team accounted for nearly two-thirds of referrals (63 percent). Referrals from this team were limited by the cap on the active caseload for an Employment Consultant being 20-25 people at any time. The conversion rate from referral to participation in the prototype was slightly higher for Moko Services: 59 percent compared with 52 percent for the West Auckland ACMHS.

The number of Māori and non-Māori participants (46) was the same for each group with some Māori service users referred by the West Auckland ACMHS team. Māori were as likely to consent to participate as non- Māori. Men made up 61 percent of those referred.

Figure 1 shows the time pattern of recruitment. After an initial high level of referrals, recruitment tailed off as caseloads became full, and clinicians became aware of the short duration of the prototype. Referrals were also lower towards the end of the year due to the seasonal slowdown.

Figure 1: Prototype referrals and consenting participants in the 6 months to December 2018



Characteristics of participants

Most participants who consented to participate in the prototype were aged 21-30 (see Table 2). Men outnumbered women (31 men and 19 women). Numbers of Māori and non-Māori participants were the same (25 in each group). The ethnicities of the non-Māori group have not been reported here due to the low numbers.

Over half of participants (28, 56%) had a diagnosis associated with psychosis (schizophrenia, psychotic disorder or drug induced psychosis). Diagnosis of psychosis is a good indicator of reach, and whether mental health clinicians are discussing employment with a broad cross-section of people on their caseload (Kongs-Taylor & Lockett, 2017). These data compare favourably with the IPS service in Auckland and Counties Manukau DHBs (Kongs-Taylor & Lockett, 2017) and are in line with a range of international implementation studies (Richter & Hoffmann, 2018).

Eighty percent of participants (40) reported that they were receiving a benefit. Three-quarters of those who reported receiving a benefit received Jobseeker Support[12] (29/40).

Table 2: Characteristics of people who consented to participate

		n	% Total
Referring Service	ACMHS	30	60%
	Moko Services	20	40%
Gender	Male	31	62%
	Female	19	38%
Ethnic group	Māori	25	50%
	Non-Māori	25	50%
Age group	18-20	7	14%
	21-25	19	38%
	26-30	15	30%
	31-35	9	18%
Diagnosis	Psychosis	28	56%
	Non-psychosis	22	44%
Benefit type at entry	Not on benefit	10	20%
	Jobseeker Support	29	58%
	Supported Living Payment	10	20%
	Unknown	1	2%
Length of time out of work at entry	<1 year	16	32%
	1-<2 years	12	24%
	2-<3 years	1	2%
	3 years or more	13	26%
	Unknown	4	8%
	In work/ not applicable	4	8%
Total		50	100%

There was variation in the amount of time participants had been out of work. Four participants were already in work when they entered the programme and were looking for support with their current employment or help to find a different job. Most of those for whom time out of work was known had been out of work for more than a year (24/40).

[12] Whether the client received this payment on the grounds of a health condition, injury or disability, or whether they were in receipt as a 'work ready' claimant, was not captured.

Programme retention and attrition

Of the 50 participants, 43 had been involved for at least three months at the time the study data were collected (the end of December 2018). The other seven had been in the service for less than three months at that time.

Sixteen of these 43 participants had exited employment support by the end of December, most commonly because they chose not to continue (12/16). Other reasons to withdraw from the service included the participant attaining their employment goals and not wanting ongoing employment support (1/16), other services such as Addiction Services being more appropriate (2/16) and the participant becoming unwell (1/16). The numbers are too low to comment on trends as to the timing of exit, although it generally appears to be after a few (2-4) months of engagement. More detailed information will be reported as the number of participants increase. Refining the collection of reasons for exit will be considered for the main trial.

Activities and outcomes as at the end of December 2018

Among the 43 participants who were able to be followed for a full three months as at the end of December, 16 (37 percent) had entered employment by the three month mark and some had had more than one job over the period. While the main focus of the prototype stage was not to assess the impact of participation on employment outcomes, these results compare well with an international benchmark of 43 percent entering employment, usually measured with a follow-up of at least a year, from implementations that are not part of RCTs (Richter & Hoffmann, 2018).

Of the 34 participants who were still active in the prototype at the end of December 2018, eight were in a planning and preparation phase, 11 were in a job search phase and 15 were employed and receiving in-work support. The group in employment made up 44 percent of the 34 participants active at the six month mark.[13] For over half of those employed, the job gained was permanent (Table 3). For 13 participants employment was full-time (30 or more hours per week).

Table 3: Employment commencements for those in employment at the end of December 2018

		n	% Total
Type of job	Permanent	8	53%
	Fixed term	2	13%
	Casual	5	33%
Hours of work per week	≤ 15	3	20%
	16-30	0	0%
	30+	12	80%
Time to any employment from entry	Up to 1 month	2	13%
	1-3 months	12	80%
	More than 3 months	1	7%
Total		15	100%

[13] This 'snapshot' measure of employment outcomes aligns with that used in some IPS studies and in the IPS fidelity review manual (Becker, Swanson, Bond, & Merrens, 2011). Here we report both a snapshot measure, and a measure that looks at employment for a cohort over a standardised three month follow-up from programme entry. The cohort measure is less prone to bias associated with variation in retention and in duration of programme participation among the current caseload, and better supports comparison across studies (Lockett et al., 2016).

Numbers in the prototype were too small to draw any conclusions about outcomes for Māori compared to non-Māori as at the three month stage, but will be reported as recruitment progresses in the main trial.

Client stories

Anonymised client stories (boxes 4-6) illustrate some of the diversity of services, activities and client experiences, and how the clinical, cultural and employment services worked together to accommodate the participants.

Box 4: Client story – Sarah* *(*Name and other details have been changed to protect privacy)*

As a young person, Sarah had done odd jobs for whānau members but had never applied for a job or worked for an organisation before. Due to her desire to work, Sarah was referred to the Employment Consultant integrated with the mental health team for support to make her employment goal come true.

Throughout the process Sarah's mental health key worker, her taurawhiri (cultural support person) and Employment Consultant took a holistic approach by working together to ensure that Sarah's employment and recovery journeys complemented each other. They met regularly to discuss Sarah's progress and wellbeing.

Not having ever applied for a traditional job was an immediate barrier for Sarah. However, her Employment Consultant walked her through the employment process in detail and together they started approaching potential employers. Sarah was also helped to set up an IRD number, bank accounts and to gather personal documents such as a birth certificate.

From day one Sarah indicated that she would like a job where she could get outdoors and feel like she had achieved something at the end of each day. Sarah recognised that having a job would not only help her financially but would help with her mental wellbeing and give her a daily routine to follow.

Within two months of job searching Sarah had successfully secured a job in a market garden, which she was excited about. Her Employment Consultant checked in on Sarah and the employer daily to see how everything was going. During week two, things took a turn for the worse and Sarah rung to say the job wasn't right for her.

Together Sarah, her key worker, taurawhiri and Employment Consultant decided that continuing with the role could be detrimental to Sarah's mental health recovery and that together they would support her to leave that role, followed by a detailed debrief. Sarah says that her confidence was boosted by the experience thanks to the support team's' quick action and guidance.

Sarah was very motivated to re-engage in the job search process now that she'd had a taste of working and realised how much support she would have. The integration of employment, health and cultural supports has been pivotal in Sarah's ongoing journey.

Box 5: Client story – John* *(*Name and other details have been changed to protect privacy)*

John had been out of work for five months when his mental health key worker referred him to an Employment Consultant as part of the Waitematā DHB IPS programme. During his first meeting with his Employment Consultant, John shared that he had lost hope of his dream to one day become a lead designer. Together they went through what John wanted to do and the practical steps needed to get John back into employment.

Together, John and his mental health team decided that the focus would be on creating a step-by-step plan to get John back into his dream career and that would support him with his unwellness triggers and symptoms around beginning to work again. John wanted to work as soon as possible for financial reasons, so efforts were made to get him a customer service role in the interim. Together John and his Employment

Consultant created two CVs and cover letters (one for customer service and one for design), and undertook an extensive job search followed by interview preparation.

Another vital part of the employment support plan was ensuring that John had the right financial supports, including a transition-to-work subsidy from W&I. The extra financial support meant one less stress for John, and meant he could focus his energy on finding the right job.

W&I arranged for John to attend a week-long customer service course to help build his confidence and resilience when interacting with people. Throughout the employment process, John's mental health key worker and Employment Consultant met weekly for progress meetings to ensure his treatment and employment plans were aligned and complemented each other.

Two months into his employment journey, John by-passed his plans of taking on a customer service role, as he landed a full-time role as a design assistant. "With encouragement, I managed to successfully secure employment in the sphere of my dream career. All I needed was a little push in the right direction from my Employment Consultant and mental health team – which has changed my state of mind," says John.

The support didn't stop with John getting a job. His Employment Consultant helped him put a plan in place to ensure he has transport to work. Moving forward, John's Employment Consultant and mental health key worker continue to meet with him to check in on his progress. His view of life is much improved and he has increased his resilience and confidence. He is enjoying an ordinary life, like other young people and will be discharged from mental health services soon.

Box 6: Client story – Hine* *(*Name and other details have been changed to protect privacy)*

Hine's experience of trauma meant that she had been out of work for seven years when she was referred to the Waitemata DHB IPS programme. Hine was lacking in self-confidence when she first met with her Employment Consultant and although she was motivated to get a job and believed it would be life-changing for her, she was also very nervous about re-entering the workforce as an account manager.

Her Employment Consultant worked with her and her mental health key worker to develop an employment support plan. Then together they put a plan in place to make sure Hine had everything she needed to get back into work. The Employment Consultant and key worker took a team approach in supporting Hine, bouncing ideas off each other about how they could help her in her goal to get a job.

Supporting Hine on her employment journey required a lot of work to build up her confidence and self-esteem. Numerous mock interviews gave her confidence when answering questions and a trip to Dress for Success for some interview clothes helped her feel more confident in her appearance. Once she started doing interviews, debriefs helped to relieve the self-doubt that she left each interview with. The mental health team focused on strategies to deal with stressors.

There were also other challenges that they navigated together. Hine didn't have a phone and this was a real barrier to finding work, so W&I successfully secured funding for a new phone.

Transport was also a challenge. Her Employment Consultant helped her with transport to interviews wherever possible and her key worker happily stepped in with transport options when required.

The team approach between Hine, the Employment Consultant, key worker and W&I meant that in just over a month Hine had secured a job. After reviewing the contract with her, her Employment Consultant took her for another trip to Dress for Success to kit her out with a work wardrobe. Her key worker helped her get a transport card, so she could commute to work on public transport.

Hine worked with her Employment Consultant and mental health team to develop a plan to support her wellness and her ongoing employment. Once she started work, they had regular meetings in person and over the phone to support her in her wellness plan.

Hine is excited to be working again and truly feels that she fulfilled her goal. She has learned a lot from the journey and her self-confidence has soared.

5. Overall view of the prototype and success factors

Overall feedback from staff

A consistent theme from the interviews undertaken for the study was the perceived success of the prototype and the positive effects it had on the mental health teams and the people they served. Feedback about the prototype was overwhelmingly positive.

A senior clinical staff member described IPS as *"one of the most positive things I've seen."* Another valued the additional expertise and dedicated resource of the Employment Consultant, explaining that "[*it is] awesome to have somebody there to do the work we can't do*."

These themes were reiterated in written input following the interviews.

> *"The team has embraced the IPS project as we realise the importance of work in a client's life. We have a young team who are enthusiastic about supporting clients and working with our Employment Consultant to assist people to realise their goal to work…*
>
> *The results of the project show that given the right opportunity and support individuals with mental illness are able to recover from an episode or period of illness and return to the workforce…*
>
> *After a period of illness clients can often be low in confidence and self-esteem making it difficult to negotiate with various organisations and their requirements. 'Walking alongside' clients supporting and guiding them to return to work cannot be underestimated and makes a great difference"* (staff member from the clinical teams).

The following were identified as particularly successful elements of the prototype.

The high level of integration between Employment Consultants and the mental health teams: Many interview participants spoke positively about the high level of integration achieved in a short time. The integration and close working relationships developed between Employment Consultants and clinical staff were considered a significant achievement, and a key difference between IPS and other employment support services.

Elements of this integration were considered to be very successful and were well-received by the clinical staff. The visibility of the Employment Consultant and the swift and direct referral process were regarded as particularly beneficial. Direct referrals from clinical staff to Employment Consultants were seen as reducing barriers for clients by removing additional steps, such as requiring a W&I appointment. Interview participants valued the additional information they were able to get by working together, allowing them to get a fuller picture of a client's situation and needs. This, it was noted, marked an important difference between IPS and other MSD-funded employment services, where client information may be held by the referring agency and not passed on to the service provider.

The ongoing discussions and information-sharing between clinical staff and Employment Consultants, and the observable positive effects of this integrated way of working on

service users, encouraged clinical staff to support the employment service. They reported that collaborative relationships were built between clinical and employment support staff as the prototype progressed.

The positive impact on the culture of the mental health teams: The introduction of employment consultants into clinical teams, and the focus on employment as a health intervention positively impacted on the culture of the teams. Interview participants explained that the IPS service caused a shift towards a more holistic understanding of the health and wellbeing of the people they served, and an increased focus on their strengths and successful outcomes. Clinical staff explained that the inclusion of employment-related discussions within the team:

> *"[has] changed the landscape of the way we talk"*
>
> *"changes the whole mood of the room"*
>
> *"reminded a lot of the people [in the team] to focus on strengths, to focus on aspirations."*

The success of the prototype was recognised by others external to the service. Several interview participants mentioned that there was demand to expand the service into other teams.

The direct relationship between the Employment Consultants and W&I programme coordinators was considered highly beneficial to the Employment Consultants, clinical staff and their clients. The Employment Consultants had a direct point of contact with W&I programme coordinators from nearby W&I service centres, who passed on job leads from W&I work brokers to the Employment Consultants. A W&I service centre manager was also available and could authorise grant applications over the telephone, rather than requiring clients to go to a W&I office.

Clinical and employment support staff members reported that having the direct contact with W&I staff made processes like grant applications easier for clients, thereby reducing barriers that can cause clients to disengage. As an employment support staff member explained, it allowed clients to *"skip the difficult stuff and get the resources they need*." Examples were provided of instances when the *"MSD contact made all the difference*".

The Employment Consultants and clinical staff valued this relationship with W&I, particularly in comparison to other employment services where links with W&I staff were limited to the referral stage of the service and did not include practical ongoing W&I support. However it is important to note that while the relationship was considered beneficial, interviewees also explained that the nature of the support provided by W&I could be made more relevant to IPS participants. This is discussed in more detail in section 8 of this report.

Success factors

Interview participants were asked what factors had contributed to the success of the prototype and the following key themes were identified. It will be important to embed these elements in any wider IPS implementations in Aotearoa New Zealand.

Credible and proactive leadership among all project partners: The credibility, proactive nature and expertise of the Waitematā DHB project team were considered success factors during the planning stage. The leadership shown by staff within the MSD project team and the service provider were also considered important. Interviewees described how positive working relationships developed between MSD and Waitematā DHB over the planning phase.

Several interview participants expressed support for the partnership between MSD and the DHB, an arrangement which differentiates this prototype and other MSD-funded employment services. The fact that the prototype was led by the DHB was mentioned by several interview participants as a success factor. Interview participants reported that having the health expertise of the DHB and established, evidence-based practices to follow was beneficial.

The DHB leadership was seen as working well for both MSD and the employment service provider because it ensured that the prototype was underpinned by a detailed understanding of, and commitment to, IPS practices as well as knowledge of the health sector and systems. The role of the Waitematā DHB project leadership team in negotiating with MSD helped the service provider to focus on implementation and delivery. The service benefitted from the existing relationships between the Waitematā DHB project leadership team and the individual mental health teams.

The influence and leadership of the steering group was also considered a success factor. The steering group was considered to have good representation and oversight at all levels, and the experience, credibility and influence to overcome barriers as they arose. However, it was also noted that the steering group meetings were difficult for some of the clinical staff members to attend due to conflicting clinical responsibilities.

Technical expertise and support with implementation from the employment service provider: In the lead up to the prototype, the employment service provider communicated regularly with the mental health teams and was often present at the clinical services, to support their planning and preparation. The IPS supervisor acted as a contact point between the mental health teams, service provider and the project leadership. As one clinical staff member explained, the Workwise IPS supervisor "*was in constant contact*" with the team in the lead-up to the prototype.

The employment service provider also conducted information sessions for the mental health teams and W&I staff involved in the service. These information sessions covered the principles of IPS, the concept of employment as a health intervention, and some guidance on how integration can be achieved. Additional information sessions were delivered by the employment service provider while the prototype was underway.

Due to their prior experience in delivering IPS, the employment service provider was able to develop a detailed implementation plan during the planning phase, despite the short timeframe. A theme that emerged from the interviews was that of the expertise and experience of the employment service provider, who was considered flexible, pragmatic and quick to deliver by clinical staff and the Waitematā DHB leadership team. An interview participant involved in project oversight thought that the service provider delivered *"a seamless, quick roll-out"* which *"you couldn't fault."*

In addition to the level of support typical from IPS supervisors, the employment support provider dedicated significant resources to the prototype. This was acknowledged by the MSD and Waitematā DHB project leadership teams as going beyond the usual supervisor role.

The positive attitudes of the clinical staff: A particularly strong theme that emerged from interviews across all interview participant groups was the positive attitude of the clinical staff and the influence this had on implementation. The employment service provider, Waitematā DHB project leadership team and MSD staff explained that the clinical teams were eager to make the prototype a success, approaching the implementation of the service with enthusiasm and a 'can-do' attitude. The clinical teams were keen to co-operate with the employment service provider to recruit participants, share information

and learn about IPS evidence-based practices. As a member of staff from the service provider explained,

> *"the level of openness and willingness of the clinical teams has been superb."*

Within each of the mental health services, a key team leader and an IPS champion were nominated to work alongside the employment support team and the steering group. The key team leaders and champions asked clinicians in the teams to consider people who could benefit from the IPS employment support service in advance of the service implementation.

Staff from the employment service provider thought the mental health teams were welcoming and supportive towards the Employment Consultants. The establishment of the IPS champions within the clinical teams helped facilitate integration of the Employment Consultant into the team. This role was considered particularly important early on in implementation to help promote and advocate for IPS.

A number of early successes in employment outcomes further increased buy-in from clinical staff. Clinical teams were able to quickly see the direct benefits of IPS for the people they served. These successes were discussed and celebrated within the teams and this seemed to contribute to a focus on clients' strengths, functional recovery, and overall wellbeing that was observed within the mental health teams.

6. Cultural responsiveness for Māori

One of the study tasks was to explore cultural responsiveness, and what changes, if any, needed to be made in the main trial. Addressing these questions is important because poor cultural responsiveness (eg lack of cultural knowledge among staff, subconscious bias, and institutional racism) in delivery could mean reduced engagement and effectiveness for Māori, and higher levels of programme attrition (Harris et al., 2006; Harris, et al., 2012; Priest & Lockett, in press).

When assessing the cultural responsiveness of IPS, the findings from the interviews indicated a distinction between the principles and practices of the IPS approach itself, and the contracting and implementation of the prototype. The principles and practices of the IPS approach were widely considered to generally align with the principles of kaupapa Māori service delivery. Features of the prototype's implementation, however, lacked cultural responsiveness. The findings highlight the need for sufficient flexibility and meaningful engagement with clinical teams to ensure that the service is implemented in culturally-responsive way.

Cultural responsiveness of the delivery of the prototype

In terms of staff concordance with the IPS participants, the two Employment Consultants were non-Māori and the IPS supervisor was Māori. The lack of Māori employment support staff within the clinical teams was noted by the employment support provider. In terms of Māori cultural expertise, the employment support provider drew on their experience of implementing IPS within another kaupapa Māori mental health service, in the Waikato DHB. The Employment Consultant who was placed in Moko Services spent time in the Māori service in Waikato to learn from the Employment Consultant and clinical team there. They also received additional support and mentoring from the Waitematā IPS supervisor on the cultural aspects of the Employment Consultant role in Moko Services.

Within the clinical teams, the staff at Moko Services involved in delivering the prototype were Māori and the service included specialist cultural support for tāngata whai i te ora participants. The services provided by West Auckland ACMHS are based on Western clinical practice, but were able to able access cultural support from Moko Services.

A number of the IPS principles and practices align well with a kaupapa Māori approach

Several features of IPS were identified by Māori interviewees as aligning particularly closely with the kaupapa Māori principles of Moko Services.

- **The zero-exclusion criteria:** IPS will support anyone who wants to work, regardless of any other criteria.
- **The recovery-oriented approach of IPS:** IPS supports clients for as long as required, regardless of how many jobs they have lost or appointments missed, or any other problems going on in their lives. This was considered a good fit with the kaupapa of Moko Services, which supports their tāngata whai i te ora for the length of their journey, using a stengths-based, holistic understanding of mental health.
- **The importance of personal relationships built face-to-face and over time:** The Employment Consultant works with clients through all phases of job search and job development, and building relationships with employers and clinical staff is an important part of their work. As one clinical staff member in the Moko Services explained, IPS is well suited to a kaupapa Māori service because "*it's all about partnerships and relationships.*"

Mental health clinicians and employment support staff interviewed, both Māori and non-Māori, considered that the service was be beneficial to, and experienced positively by, Māori participants. The view of the Moko Services team was that the combination of clinical and cultural services provided by the team was vital for supporting tāngata whai i te ora to engage with and succeed in obtaining competitive employment through IPS.

However some staff were critical of the decision to implement a service about which the effectivess for Māori is unknown. A particular point of concern was that the IPS approach was based on services developed in the United States and had not been considered in relation to native American populations, or indigenous groups in other countries.

Some features of the contracting and implementation processes conflicted with the kaupapa of Moko services

While the IPS approach itself was well received, many interview participants, including staff from Moko, suggested that greater collaboration to determine *how* the service would be implemented would lead to a greater understanding of IPS and a more culturally-appropriate implementation.

Issues that arose as a result of the limited time and resources to set up the service were amplified for Moko Services because of the additional components required to uphold the tikanga underpinning the service. Interview participants explained that extra time was required to organise and conduct pōwhiri to welcome new visitors and staff, as well as to orientate the Employment Consultant in a cultural service and build relationships between the service provider and clinical teams. These requirements placed an unexpected additional workload on the clinical staff.

The eligibility criteria (age and location), were considered to conflict with the approach of Moko Services

Staff explained that being unable to offer IPS to tāngata i te whai ora who were aged over 35, or those who were accessing the service at their North Shore location, was challenging both morally and practically (due to its impact on referral numbers). The short-term nature of the prototype was also criticised because it caused uncertainty and limited the length of time that the IPS service could be provided. This conflicted with the approach of Moko Services, which was to provide support to their tāngata i te whai ora throughout their recovery.

Workforce development could support cultural capability

Interactions and relationships are part of the kaupapa of Moko Services and so it was considered important that the Employment Consultant could integrate fully into the culture and everyday activities of the team. While this was considered to have gone well overall, interview participants reported that integration could have been improved by a more comprehensive cultural orientation during the early stages of implementation. As noted, efforts were made to support the Employment Consultant in this regard.

Several interview participants suggested that supporting the Employment Consultant with cultural training could help ensure that the implementation of IPS was culturally-appropriate for clients. This may be an important factor to consider for other culturally-specific services, such as Pacific mental health teams.

Consideration of the importance of having Māori staff to deliver a kaupapa Māori service was a theme raised in several interviews. The Employment Consultant who was placed at Moko Services was not Māori and while the clinical staff in Moko services spoke very highly of the Employment Consultant, the potential benefits of having a Māori workforce in

a Māori service were noted. These included: a deeper understanding of the kaupapa of the service, shared cultural values (with the team and with clients), and faster integration into the team. It was noted that the limited time available for setting up the prototype did not allow for the employment service provider to recruit a Māori Employment Consultant. It was also noted that the Māori workforce in the employment services sector is limited. Therefore a longer-term consideration may be to increase opportunities for Māori to enter, and develop capacity within, the sector. The presence of a Māori IPS supervisor was considered beneficial in this prototype.

7. Other implementation learnings

The study interviews also aimed to identify areas where issues arose or improvements could be made. Despite some difficulties, all interview participants stressed how well they thought the prototype had gone overall. This section should be read with this in mind.

The following key themes suggest ways in which the IPS trial at Waitematā DHB can be improved. They may also have general relevance to the implementation of IPS services in Aotearoa New Zealand.

Staff expressed discomfort about the service being limited to those aged 18-35: The most consistent theme in the interviews was an opposition to the age criteria. Most interview participants, when asked their view about what changes should be made to the service, suggested that the age criteria be removed, expressed discontent with implementing the age limit and questioned the ethics of excluding people aged over 35 who could benefit from IPS. One member of staff noted that:

> *"There are so many people over 35 who want to find work. And there is no alternative service for them…that is integrated like IPS"*

The mental health teams were informed of the decision to limit the service to those aged 18-35 during the planning phase. However, some staff members were not clear about the rationale for the age limit and thought this had not been clearly communicated to the teams.

The short-term nature of the contract for the prototype, and changes to the service design, were problematic: The decision to conduct a prototype was considered by some interview participants to be problematic, because of the uncertainty it caused. Mental health services were required to invest time and resources, with no guarantee of a service extension. A significant effort was also required by the DHB project team and Workwise to build relationships across different teams and partners. Several interview participants thought that the lack of assurance about the future of the service risked losing goodwill and support, and could damage relationships for future services.

A need to build on the success of the prototype without losing momentum was mentioned. It was suggested that MSD needed a greater understanding of the implications of short-term contracting and changes to service design on service provision in the health sector. It was also noted that the prototype design included employment targets for the service to achieve. This was considered by some interview participants to be inappropriate given the short timeframe. The inclusion of outcome targets risked putting pressure on the services to get employment results rather than focus on setting up the service with fidelity to the IPS principles and practices.

A theme that emerged from the interviews was the importance of relationships with service providers in the employment services sector, and the need to build relationships with, and the capacity of, providers interested in delivering IPS. While the closed procurement process was appropriate for the prototype, it was suggested that, going forwards, employment service providers should be invited to collaborate early in the planning process.

The limited timeframe to prepare for implementation put pressure on mental health teams: Despite the long time period between the initial service proposal and implementation, the number of issues to be agreed during negotiations between Waitematā DHB and MSD caused delays. These issues included: ethics approval for the study, data sharing between MSD and the DHB, procurement and contract details. This limited the time available for the frontline and clinical staff to address various administrative and logistical items, such as setting up desk space, phones and access to

computer systems for the Employment Consultant. This additional strain in the early stages of service implementation was a challenge for staff who had existing clinical commitments.

Further to the administrative workload, time and resource was required to fully integrate the Employment Consultants into the teams, to complete reporting requirements and attend governance or operational meetings. While some of this work was planned for, some was in addition to that which had been expected by the clinical teams.

Based on this experience, several interview participants thought that a project support staff member as part of the mental health teams would help the service run more smoothly.

Another strong theme that emerged from the interviews was that the mental health teams would have liked more consultation and information during the planning stage about how the service would be implemented and the role of clinical staff. The IPS supervisor was praised for providing information about IPS in the short lead-in time prior to implementation, but some interview participants explained not all clinical staff had a good understanding of what the service would entail.

There is an ongoing need for training to embed practice in clinical teams and build IPS capacity in the employment services sector: A common theme from the interviews was the importance of ongoing training for clinical staff to build knowledge of IPS. It was recognised that, while the positive attitudes of clinical staff helped the service, there was still work to do to embed some of the principles of IPS. In particular, embedding a view of employment as an intervention that can help, rather than harm, was recognised as a long-term process requiring a significant shift in thinking.

Another long-term process is that of integration. While an impressive level of integration was achieved in this prototype, it was acknowledged that embedding a practice of sharing information and seeking advice between the Employment Consultants and clinical staff, would take time. Some staff thought that clinical expertise was under-utilised by the Employment Consultants, who could benefit from a better understanding of the mental health conditions and treatments their clients are experiencing, to improve coordination between employment plans and clinical plans.

Several interview participants talked about the importance of building the IPS capacity across a range of service providers in the employment services sector, and developing an IPS learning community in Aotearoa New Zealand.

Inconsistent information sharing within Work and Income can cause problems for clients: The Employment Consultants and W&I programme coordinators were frequently in contact to discuss job leads and any benefit issues experienced by clients. However, information about W&I clients who were participating in IPS was not shared in a systematic way within W&I. The interviews indicated that the scheduled monthly meetings often did not occur due to time constraints. Instead, the programme coordinators took note of any W&I clients participating in the service and added notes about IPS participation into clients' electronic records so that case managers were kept informed. However, the interview participants explained that notes were easy to miss and sometimes 'got lost' in the client management system. Consequently, case managers were not always aware that their clients were meeting their benefit obligations and participating in IPS and they didn't always know about the IPS service.

On several occasions this led to case managers mistakenly recording clients as failing their benefit obligations. If not corrected, this could result in benefit sanctions. This issue was raised in several interviews and, while it was not considered to be a large-scale problem, it is an important one to address. These incorrect obligations failures cause stress to clients

and, as one staff member explained, can damage the client's relationship with the Employment Consultant and their trust in the IPS service.

The type of support provided by Work and Income could be refined to be more relevant to IPS: The programme coordinators liaise between W&I and the Employment Consultants and the level of collaboration meant that a high score was achieved for this item in the fidelity review (as outlined in Section 8 of this report). However, in the interviews it was suggested that it may be more suitable for other W&I staff such as work brokers, who have direct access to job vacancy information, or case managers, who can provide client-specific advice on benefits to also have a direct link with the IPS programme. The programme coordinators advised Employment Consultants about how to find out about benefits, but were unable to access detailed benefits information themselves and therefore could not provide individualised benefits counselling. This was noted in the fidelity review, which recommended that W&I case managers provide advice about benefits (Reese, 2019).

Some clinical and project staff thought that a stronger direct relationship between the mental health teams and W&I staff would be useful, to share information about client needs and keep W&I records up-to-date. It is important to note that not all clients receiving benefits necessarily have a dedicated W&I case manager. It was suggested that a W&I staff member who could provide both client-specific benefits counselling and job information be assigned to IPS.

8. Fidelity to IPS principles and practices

Fidelity reviews are an integral part of IPS and are used as a developmental tool to help improve service quality. As part of the study, the degree of IPS fidelity in the prototype was assessed through an independent fidelity review conducted using the IPS-25 Fidelity Scale (Becker, Swanson, Bond, & Merrens, 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 in the main trial.

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 IPS Employment Support'. The IPS fidelity scale used for this prototype has been adapted from the Dartmouth Supported Employment Fidelity Scale (Becker et al., 2008) for use in Australia and New Zealand.[14]

Rating information was collected from multiple sources including interviews with the IPS Employment Consultants and the IPS Supervisor, clinical staff, and team leaders and managers at Waitematā DHB and Workwise, a Moko Services cultural advisor, clients, and W&I staff. In addition to the interviews, the reviewer observed the Employment Consultants conducting job development support with clients, observed a team meeting, and reviewed the Employment Consultant schedules, employer logs, client lists and job outcome spreadsheets.

The assessment, interviews and observations were conducted by an independent reviewer with support from an IPS specialist from Work Counts. Cultural support was provided to clients for the client group interview, however cultural support was not available to the Māori staff who were interviewed. Adherence to IPS supported employment was assessed at the 'agency' (agency includes the clinical services and the employment support services) and team level rather than the individual practitioner level.

The review was conducted in November 2018, when the prototype had been in operation for five months. The full fidelity review report is available (Reese, 2019).

Overall assessment

The prototype was scored at 97/125 on the IPS-25 Fidelity Scale giving it a rating at the upper end of 'Fair Fidelity', and close to the 100 point threshold for being categorised as 'Good Fidelity'. A fair fidelity score is a common baseline assessment for a new IPS service. The scores for each item are shown in Table 4.[15]

Overall, the reviewer commended the teams for their success in implementing many elements of IPS in a short period of time. Particular mention was made of the combined efforts of the mental health clinicians and employment team, along with a collaborative approach established with W&I, to implement IPS practices. Reviewers noted clinicians were very positive about the programme, commenting on the benefits and a cultural shift

[14] The IPS fidelity scale used for this prototype was the 'ANZ' scale (Supported Employment Fidelity Scale Australia and New Zealand Version 2.0, 28 October 2011). It was adapted by Geoff Waghorn (Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, Australia).

[15] The format for Table 4 is adapted from Browne, Stephenson, Wright, & Waghorn (2009)

in the mental health services since the Employment Consultants started attending weekly mental health team meetings.

Table 4: 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% 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 Consultants 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 of competitive employment	*Competitive work is promoted through multiple strategies*	√				
8.	Executive team support for supported employment	*Agency executives and senior management 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			**97**				

The prototype achieved full implementation in nine of the 25 items on the fidelity review. The particular areas where high fidelity was achieved include: the integration of the Employment Consultants into the mental health teams, the diversity of jobs and employers, and staffing (relating to Employment Consultant caseloads and services provided).

The reviewer noted that as the prototype had only been in place for five months at the time of the fidelity review, some of the criteria for particular items could not be scored.

Staffing

The prototype scored 5 (full implementation) for each of the three items in the Staffing section with Employment Consultants having suitable workloads, focused on providing employment services only, and delivering all phases of vocational services. This is a significant achievement.

It was noted that Moko Services staff reported difficulties in finding people who met the age criteria of 18-35 years who wanted to participate in the programme. Both clinical teams wanted to be able to refer people outside of this age range.

Reviewer recommendations included increasing the caseload of one Employment Consultant to maximise access, continuing to ensure Employment Consultants provide only employment services, and offering education supports when education is related to a client's career goal.

Organisation

Most items in the Organisation section scored highly, achieving either a 4 or 5 in the fidelity review. The reviewer commented that rehabilitation was well integrated with mental health services as Employment Consultants drew most of their caseload from the two mental health treatment teams (scoring 5). There appeared to be frequent team member contact on shared clients (scoring 4) with good collaboration regarding clients' issues, progress and needs (scoring 4). The reviewer also commented on a high level of collaboration between Employment Consultants and W&I staff, with Employment Consultants having access to W&I team resources and expertise (scoring 5).

The vocational unit was appropriately structured and led by a supported employment team leader (scoring 5). Importantly, there appeared to be strong executive support for the IPS prototype with leadership from both the DHB and Workwise demonstrating a good knowledge of the IPS approach and commitment to implementing it (scoring 4).

Two items in this section stood out as having lower scores: Zero exclusion (scoring 3), and Agency[16] focus on competitive employment (scoring 1). These items were identified as areas for focus in the coming 12 months.

[16] 'Agency' is used in the fidelity review to refer to the clinical services and the employment services together

Full implementation of the Zero exclusion item means that no additional screening should be applied when referring clients to employment services. A score of 3 for this item was driven by mixed practitioner views on referring clients to the employment support services, with some preferring to address health issues before, rather than in tandem with, employment support. The reviewer noted that it is usual for this sort of cultural change to take more than six months to embed. Their recommendation was to continue to educate mental health practitioners on the importance of zero exclusion and employment as part of recovery. When scoring this item, the reviewer did not take into account the age-related eligibility criteria that limited service eligibility to people aged 18–35. This is because the eligibility criteria were a contractual requirement of the service delivery teams. Nevertheless, a recommendation was made that the age criteria be reconsidered.

A score of 1 for Agency focus on competitive employment means no implementation to the IPS principles and practices for that item. Full implementation of this item requires competitive work to be promoted through multiple strategies, with opportunities and support to consider employment at all stages of a service user's involvement in clinical services, and that this is also the primary focus of the employment support being provided. The reviewer acknowledged the programme was in its early stages, meaning that two of the five criteria for this item were not assessed, ie: that clients were supported to share their return-to-work stories, and that the agency measured the rate of competitive employment. The overall score for this item should be considered with this in mind. Key recommendations for improvement included revising the DHB intake process to ensure that clients are asked by their clinical practitioners about their interest in employment, and ensuring clinical practitioners discuss employment on at least an annual basis with all clients with serious mental illness.

Services

Scores were mixed for items in the Services section.

The prototype was considered to be fully implementing items on Diversity of job types, Diversity of employers, and Competitive jobs (ie, permanent or temporary jobs in the competitive labour market rather than 'transitional', sheltered or voluntary work).

The initiative scored a 4 on a range of other Services section items including: Work incentives planning; Rapid job search; Individualised job search; Job development – frequent employer contact; and Assertive engagement and outreach by integrated team management.

The Work incentives planning item acknowledges that the risk of losing welfare benefits can discourage clients from moving into employment. The IPS team and participating W&I office worked closely to ensure support of shared clients, including through the use of Special Needs Grants and W&I products to support wellbeing, employment and education. The reviewer noted, however, that more detailed benefits planning, which could involve discussing different earnings and hours of work scenarios and their impact on benefits, would be useful to clients.

While the items for Rapid job search for competitive employment, and Job development – frequent employer contact, appeared to operating well, better documentation of contact was recommended. Employment Consultants were also encouraged to ensure that they made at least six face-to-face weekly contacts with employers who had hiring authority, rather than the current five.

Clients were supported with Individualised job searches, with job search plans that included their desired job type and preferences. Reviewer recommendations included

more deeply understanding a client's preferences by asking them, their family, and their mental health team about previous work experience, strengths and interests.

The item for Assertive engagement and outreach by integrated team management also scored a 4. The prototype was implementing five out of six strategies identified to maintain contact with clients even if appointments were missed.

There were five items in the Service section that were rated a 3 on the IPS fidelity scale: Disclosure; Ongoing, work-based vocational assessment; Job development – Quality of employer contact; Individualised follow-along support; and Time unlimited follow-along supports.

Under the Disclosure item, the reviewer noted that while clients appeared free to choose whether to disclose personal information about their health condition, there was no evidence they were consistently helped to consider the pros and cons of disclosure to an employer, or that the topic was revisited over time. The reviewer recommended more frequent discussions about disclosure, and the implementation of a disclosure worksheet to assist that conversation.

A more robust process and career profile documentation was also recommended for the Ongoing, work-based vocational assessment item. While the prototype used a Return to Work Assessment that measured a wide range of variables, it did not include a comprehensive work history or review of what clients had liked or disliked about previous jobs.

The item Individualised follow-along support reflects the idea that helping clients succeed at work is as important as finding them work. While a job support/wellness plan was in place for those clients employed, the reviewer noted that the range of supports was relatively narrow and primarily consisted of phone calls. The reviewer recommended that vocational unit meetings be used to discuss support plans for recently-employed clients, and records be reviewed for working clients to ensure they have appropriate support.

More regular, face-to-face job supports were also recommended to achieve better fidelity to the Time-unlimited follow-along supports item. While the reviewer found evidence of face-to-face contacts with employed clients a week before starting a job, no clients received support within three days of starting work, and only half had ongoing weekly contacts.

The item for Job development – Quality of employer contact was also rated at 3, but the reviewer noted difficulties rating this item as they only had a brief opportunity observe Employment Consultants using job development techniques. Recommendations for improvement included Employment Consultants being strategic about which employers to visit with ongoing face-to-face visits used to gain an understanding of their business and hiring preferences.

The prototype was rated a 1, or no implementation, on the Community-based services item. To score well on this item, services should be provided mostly in the community with the goal for Employment Consultants to spend 65 percent of their work week in community settings. The IPS reviewer encouraged Employment Consultants to increase the amount of time outside of the office. This can include suggesting community settings (such as a library) for client meetings, going job searching with clients and visiting employers to learn more about their hiring preferences. The reviewer also suggested reducing the number of mental health team meetings Employment Consultants attended to allow more time in their schedules.

Recommendations for immediate focus

Items recommended for focus over the coming 12 months were: Agency focus on competitive employment, Zero exclusion, Time-unlimited follow-along supports, and Community-based services. The reviewer recommended agency partners meet to examine the current design and structural supports and develop a Partnership Improvement Plan, with commitment from all parties to build on the work to date. A recommendation was that the partners consider adding technical assistance and project support to assist staff to implement the strategies in the plan.

9. Limitations

An inevitable limitation of the design of the prototype was that ability to achieve fidelity to IPS principles and practices was limited by the timeframe. In particular, fidelity to the principles of providing time-unlimited supports (given that there was no guarantee the initiative would continue) and zero exclusion (due to the contractual requirements to limit the age range) could not be achieved. As noted, clinician engagement may have been lower than otherwise due to the limited numbers of participants able to be referred into the prototype. More generally, cultural change, learning and development, and partnerships found to be associated with successful implementation (Papworth, 2017) are unlikely to have had sufficient time to fully develop within the short window of the prototype.

Another important limitation was that the implementation study of the prototype was not able to capture clients' experience or satisfaction with the service. Responses to a client satisfaction survey, including whether participants felt their IPS Employment Consultant understood and respected their culture, and whether the service fitted with their cultural identity were intended to capture participant feedback about the cultural acceptability and experience of the service. . Unfortunately there were too few responses for results from the survey to be used in the study. Currently, no alternative standardised client satisfaction instrument exists in the IPS literature (Viering et al., 2015).

Neither the fidelity review nor the staff interviews could cover every person involved in delivery of the prototype due to time and resourcing constraints. As a result, findings from these two sources do not always reconcile, and there may be some views and experiences that were not captured in this study.

Researchers who conducted the fidelity review and staff interviews were not Māori and the use of culturally-responsive research methods was limited. Cultural support was offered to the IPS participants who were interviewed for the fidelity review, however this support was not provided for the interviews with Māori staff. This may have affected the findings related to cultural responsiveness of the prototype. Any further research on this topic should ideally be conducted by Māori researchers and utilise kaupapa Māori or culturally-responsive (if the researchers are not Māori) research expertise.

The study focussed on employment outcomes in the short term but did not examine changes in wider aspects of health, wellbeing, or quality of life for participants and their families and whānau. Few studies of IPS have examined impacts on these outcomes (Kinoshita et al., 2013; van Rijn et al., 2016). A task for the main trial is to consider the feasibility of capturing information on changes in these domains for participants, and assessing the impact IPS makes.

Finally, while the employment outcomes of participants in the short period of the study were encouraging, the study was not set up to assess the degree to which these outcomes reflect the impact of IPS, or the extent to which they were sustained. These are tasks for quasi-experimental impact evaluation as part of the main trial.

10. Discussion and recommendations

The prototype generated useful and important lessons, both for progressing to the main trial in Waitematā DHB, and for possible future scaling-up of IPS nationally.

A number of important factors were identified to support successful implementation of IPS services. These are:

- credible and proactive leadership across all project partners
- technical expertise and implementation support
- willingness of the clinical teams to support the prototype
- contracting terms and conditions that support the delivery of the evidence-based IPS principles and practices.

Several themes were identified that suggest areas for improvement. Based on these findings, the following recommendations can be made for the IPS trial at Waitematā DHB, and to inform possible future scaling-up.

Remove limits on eligibility

The findings suggest value in removing the age limit on eligibility. The age limit was not supported by the mental health teams and was challenging to implement in practice. Demand for the service was perceived to be high among people over the age of 35.

The findings also suggest that the contractual requirement that 80 percent of participant places be reserved for benefit recipients should be removed. The majority of Waitematā DHB IPS clients were benefit recipients in any case.

Removing limits on eligibility would align the service more closely with the zero exclusion principle of IPS.

Give attention to cultural responsiveness in service planning, implementation and evaluation

An aim of this study was to consider how the prototype worked for Māori and how IPS can be implemented in a culturally-responsive way. The inclusion of Moko Services in the prototype provided an opportunity to understand how IPS can be implemented into a kaupapa Māori mental health service.

The study findings indicate that there is potential for IPS to work well for Māori. A notable finding is that the IPS principles and practices felt culturally relevant to the Moko team and were considered to be experienced positively by Māori clients.

However, the study generated important lessons about the implementation of IPS into a cultural service. It confirmed that it is important that meaningful engagement with stakeholders is built into the planning phase of a new service to ensure cultural responsiveness, and time for this is allowed for in the contracting phase. It is also important that external funders and project leads acknowledge that additional time and resources to honour cultural protocols and principles and conduct relevant cultural training are required to implement IPS into a cultural service.

It will be important to build the cultural capability of the workforce if IPS is taken to scale. Programme funders have the potential to play an important role in developing a Māori and Pacific workforce in the employment services and clinical services sectors. In the context of the social workers in schools service, this involved provision of study awards, and co-ordination of regular conferences (Wilson et al., 2018). Other mechanisms include making workplaces more generally welcoming and culturally friendly, and upskilling colleagues to be more culturally responsive.

More research on attention to culture is needed. Priest & Lockett (in press) highlight the "*paucity of vocational rehabilitation literature on attention to culture and supporting Māori people with mental illnesses into employment*". 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 could consider whether documenting best practice in the cultural context of Aotearoa New Zealand would be additions to, or cultural overlays[17] for, IPS practices and principles, technical assistance and the fidelity review. This study could be followed by work to consider how cultural adaptations can be made to IPS delivery to meet the needs of Pacific and other ethnic groups.

Carefully consider the impact of contracting arrangements on service delivery and whether contracting for outcomes is appropriate

Contracting for employment outcomes may not be appropriate when services need to balance employment and mental health goals. A possible alternative is to contract for delivery of services aligned with evidence-based practices and principles, and with best practice for cultural responsiveness.

Conducting a pilot or prototype is a recommended step in implementation science (Fergusson, Mcnaughton, Hayne, & Cunningham, 2011), and in this case has generated useful insights. However, when there is a high expectation that a larger trial will follow, it is important to carefully consider the contracting arrangements for the pilot or prototype stage.

At Waitematā, MSD's decision to only contract for the prototype phase created complexity, uncertainty about service continuity and was a challenge to clinician buy-in and successful implementation. For any future similar initiatives, it would be more appropriate to contract for a full trial with an initial prototype stage.

More generally, this study highlighted a need for longer contractual timelines to allow for greater consultation with clinical teams in the planning phase, and for the clinical teams to prepare for IPS. The following timeframes would be reasonable:

- mental health teams to be approached and co-design started three to four months before the roll-out of the IPS service
- provider on-site orientation, access and other administrative issues, and introduction to teams to start two months before the roll-out of the IPS service
- IPS information and awareness sessions to start one month before the service begins, and to include clinical teams and W&I staff.

It is also important to emphasise that time required for consultation and planning is time diverted from clinical responsibilities, and that it is important that this time is well spent. In any future scaling-up, more enduring, longer-term, contracting arrangements would support relationship building with mental health teams, and allow them to make longer-term plans for their resources and activities to support IPS.

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

Resource ongoing technical assistance and independent fidelity reviews

Findings from this study highlight the important role that technical assistance for implementation, training and conducting independent fidelity reviews can play in ensuring high quality implementation. These will be useful elements to retain as providers are engaged to deliver the main trial of the Waitematā initiative, and additional mental health teams gain access to the service.

Mechanisms for embedding fidelity reviews and technical assistance for implementation and ongoing delivery could be considered in any future national scaling-up of IPS. Creation of a quality mark linked to fidelity reviews and standards could ensure programme quality (Priest & Lockett, in press). Strengthening the capability of a range of service providers to deliver IPS technical assistance and fidelity reviews would support this. The delivery of fidelity reviews and technical assistance should take into account cultural adaptations considered necessary, and, as noted, this could be usefully informed by further research.

Fidelity reviews can be time-consuming for clinical and administrative staff, and services may wish to consider adapting review methods in order to reduce the burden on staff.

In the current study, fidelity reviews are being conducted as part of the study and therefore they draw on evaluation funding. In future implementations, it would be desirable if the fidelity reviews and technical assistance was a routine part of contracted service delivery and planned for and funded accordingly. Provision of technical assistance, like the fidelity reviews, can be provided independently of employment services.

Refine the role of W&I to ensure access to appropriate benefits information

The employment service provider and clinical teams saw the inclusion of staff from local W&I sites within the IPS service model as highly beneficial to participants, and the level of collaboration was commended in the fidelity review. However, the role of W&I staff, and the link between frontline W&I staff and the IPS Employment Consultants does need clarification. More relevant support could be provided by W&I staff with direct access to benefits and job information. As was noted in the fidelity review, more ready access to information about benefit entitlements and benefit counselling to work through different employment scenarios would be of assistance clients.

Greater awareness and understanding of IPS by W&I case managers and more systematic recording of client participation in W&I computer systems would help ensure that W&I clients who participate in IPS continue to receive their correct benefit entitlements. Some thought as to how this data can be more effectively shared with case managers is also needed.

Implement an effective method of collecting participant feedback

Surveys were not an effective tool for gathering feedback from the people participating in the prototype, as indicated by the low number of responses. Other options include making better use of routine tools used to gather information on service user experience within the DHB, informal interviews with groups of participants, and case studies similar to those included in this report. It is important with all these options to consider how evaluators can effectively capture the experiences of participants who disengage from the service or have negative feedback.

11. Conclusion and next steps

The IPS prototype at Waitematā DHB can be considered a significant achievement. It was implemented with no major problems, experienced positively by clinical teams, and perceived to have benefits for participants. This was particularly impressive given the short timeframes. Feedback from stakeholders was overwhelmingly positive and there was widespread support for the continuation and expansion of the service.

Particular factors that contributed to the success of the prototype were: credible and proactive leadership within each of the project partners and the cross-agency steering group; the positive and eager attitude of the mental health teams; and the technical expertise and dedicated support of the employment service provider. Additionally, the immediately noticeable benefits of the service – such as the ease of referrals and the early successful outcomes for clients – contributed to success of the implementation by increasing support from the clinical teams. The robustness of the IPS evidence base and the health-led implementation of this prototype were also considered important success factors.

Based on success in the prototype, the main trial of the Waitematā initiative will proceed. The main trial will expand access to IPS to clients throughout the DHB's Adult Community Mental Health Teams without any age restriction. Funding does not cover expansion to addiction services. Learnings from this study will inform the next stage.

Future evaluation activities will include further fidelity reviews, and continued monitoring. A Māori-centred study is also planned. The aim of this study will be to help funders, providers, fidelity reviewers and IPS teams to develop cultural responsiveness in the delivery of IPS within the Aotearoa New Zealand context. Impact evaluation will involve a quasi-experimental study carried out using linked data held in the Stats NZ Integrated Data Infrastructure.[18] Although not without limitations, these linked data are an important new resource for building evidence about what works (He Ara Oranga, 2018), but there is a need for greater transparency about their existence and use (Gulliver, Jonas, Fanslow, McIntosh, & Waayer, 2018).

[18] See www.stats.govt.nz/integrated-data/integrated-data-infrastructure/

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Appendix: Information sheet and consent form

Participation Information Sheet
Individualised Employment Support – Helping you to find work

We'd like you to take part in a study to help us find ways to support people into work.

What is the Individualised Employment Support study about?

Getting into work is a goal for many people who are coping with mental health. We know finding a job can be hard and that support to find work can help.

We're inviting you to take part in a study on the Individualised Employment Support service that helps people to find the right kind of work for them.

The study will involve up to 50 people over a nine month period in an Individualised Employment Support service run by the Waitemata District Health Board (DHB) Adult Mental Health Service, located at the Waimarino Building, 33 Paramount Drive, Henderson.

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

- What you like about Individualised Employment Support?
- Does the service work well or do we need to make changes?
- Does the service respect and understand your cultural needs?

What will taking part involve?

- We'll introduce you (and your whānau if you like) to your Employment Specialist from Workwise. This is someone who's here to work closely with you to understand your personal interests and experience to help find the right kind of work for you.
- You'll have regular meetings with your Employment Specialist to discuss your work goals and the jobs that interest you. Then they'll help you look for work.
- When and where you meet, and the amount of time you spend with your Employment Specialist, is based on your preference. For some people this might mean meeting with their employment consultant for an hour or so every week, for others it may be two or three times a week, dependent on the plan you will come up with together.
- You can meet with them here at Paramount Drive or at their offices or wherever suits you in the community, this might include at a cafe or library etc. From time to time people may be met at their homes.
- Once you're in a job, your Employment Specialist will stay in touch with you to support you in your job.
- Your Employment Specialist will be available until the end of the study (at least until February 2019).

- Your Employment Specialist will attend weekly meetings with the Waitemata DHB Adult Mental Health Service, and may have access to your mental health information where it's relevant to you finding work.

Any information shared about you is subject to the same strict confidentiality standards as for all healthcare professionals. Feel free to talk to your nurse, key worker or doctor about how much information you'd like your Employment Specialist to know about you, your whānau and your mental health.

What you need to know about taking part

The Ministry of Social Development (the Ministry) is funding the study and helping us to get our Individualised Employment Support approach right. If you are getting a benefit from Work and Income and want to take part in this study, we'll need to share some of your information with the Ministry. This includes:

- your name
- your date of birth
- the date you start taking part in the study
- the date you start paid employment and the number of hours per week
- the date you finish taking part in the study
- any reason(s) you stop taking part in the study.

Taking part and/or withdrawing from the study will not affect your benefit or any regular payments from Work and Income unless you find paid work. Your employment specialist will talk through with you any possible impacts on benefits of differing hours of work.

The Ministry will also get limited information about the whole group of people who take part in the study. This includes:

- how long people take part in the service
- the average number of hours an employment specialist spends with each person
- the steps people take towards work and
- any employment outcomes.

This information will not be linked to individual people.

The reason why we share your information with the Ministry is so they know the right people are being offered the opportunity to take part in this study, and whether Individualised Employment Support is working well to meet your needs and help you into the right kind of work.

How will the study be reviewed?

People who are experts in setting up this kind of service will review the service later in the year. This will help us to learn what does and doesn't work and how we can improve.

The review will involve talking to the Waitemata DHB Adult Mental Health Service and your Employment Specialist about how the service is going - they may also want to review records.

They will also invite a small group of people from the study to talk about their experiences of the service. Any responses will be anonymous. If you're invited to take part, you can say 'no' and this won't affect the Individualised Employment Support service you get.

Of course we'll welcome your feedback at any time.

What are my rights?

- Taking part is voluntary – you don't have to take part.
- You may withdraw from the study at any time, without giving a reason. This will not affect your future health care.
- At any point you can ask to see any information collected about you as part of this study and correct it if it's wrong.
- Your identity will be kept strictly confidential. Nothing which could identify you personally will be included in any published reports on this study.
- A summary of the study's overall results will be available once the study is finished.
- We encourage you to talk with your whānau or family, hapū or iwi about taking part in this study.

Who pays for the study?

- You don't have to pay to take part in Individual Employment Support - the Ministry of Social Development is funding the study.
- You won't get paid for taking part in the study.

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.

If you decide to take part, you'll help yourself while also helping us get better at supporting other 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 Fiona Conlon from the Ministry of Social Development's Research and Evaluation team. Phone: ** or Email: **.

If you have any questions about the Individualised Employment Support service, you can contact the clinical lead of this study: Dr Sheryl Jury, Public Health Physician, Waitemata DHB and Auckland DHB. Phone: **. Email: **.

If you want to talk to someone who isn't involved with the study or the service, you can contact an independent health and disability advocate. 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 the administrator for He Kamaka Waiora (Māori Health Team) by calling 09 486 8324 ext 42324.

This study has received ethical approval from the Health and Disability Ethics Committee (Ref 18/STH/57). Their contact details are: Phone: 0800 4 ETHIC (0800 4 38442). Email: hdecs@moh.govt.nz

Participation Consent Form:
The Individualised Employment Support study

Please read this carefully then write and sign your name at the bottom of the page 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 Individualised Employment Support study and want to take part.
- I've have been given the opportunity to ask questions and my questions have been answered.
- I'll take part in the Ministry of Social Development's Individualised Employment Support study provided by the Waitemata DHB Adult Mental Health Service.
- If I'm getting a benefit, the Waitemata DHB Adult Mental Health Service can share the information below with the Ministry of Social Development so they can monitor the study including what results the service achieved for me:
  - My name
  - My date of birth
  - The date I start taking part in the study
  - The date I start paid employment and the number of hours per week
  - The date I finish taking part in the study
  - Any reason(s) I stop taking part in the study
- I understand that my contact information may be used in the future to invite me to take part in an interview about my experience with Individualised Employment Support. I understand I can agree to an interview or not – it is up to me.
- I understand I can withdraw from the study at any time and this will not affect the care I receive from the Waitemata DHB Adult Mental Health Services Team.

Name: …….

Signature: ……. Date: …….

Name of person who explained the study to me: …….

Signature: …… Date: ……