Employment and mental health is everyone's business

The very low employment rates of people who experience mental health conditions are both a health *and* a welfare issue.

By taking a whole of government approach to employment and mental health we can reduce the number of beneficiaries and achieve health gains – faster.

There is a significant and measurable opportunity to improve the effectiveness of the Ministries of Social Development and Health's investment for this group by integrating evidence-based supported employment services into mental health care.

What we know

- People who experience mental health conditions form the largest group of current and new claimants of Work and Income benefits.[i] [ii]
- People who are in contact with mental health services have the highest 'want to work' rate but the lowest employment rate for any disabled or disadvantaged group at less than twenty per cent.[iii] [iv] [v]
- Evidence-based supported employment (EBSE) services are three times more effective than the best available vocational rehabilitation in getting people into paid jobs.[vi]
- EBSE services are effective in New Zealand. For example, among young people with first episode psychosis the employment outcome rate is 69 per cent.[vii]
- EBSE services cost no more, and probably cost less, than existing vocational rehabilitation services[viii] and are a good return on investment.[ix]
- The key to effectiveness is integrated working. Standard treatment alone is not enough to support a return to work.[x] Health services need to deliver employment focused healthcare for everyone of working age, offering a work conversation as part of routine clinical treatment and encouraging uptake of integrated employment support services. People don't have to be symptom free before returning to work.[xi]

What we believe

- The extension of EBSE services into primary and secondary mental health care has the potential to reduce the number of benefit claimants in New Zealand and improve the effectiveness of the current investment in employment services for this group.
- As there is unequivocal evidence on what works programmes which align to this evidence base should be made available for people to secure their social and economic participation.

"Specialist Interventions would be required to support people with mental illness into work as mainstream employment reforms and programmes have been found to have a limited effect ... For people with severe mental illness, evidence-based supported employment programmes are more effective at helping people to find jobs than are pre-employment training schemes" (Welfare Working Group, 2011, p156).

EBSE is already working in New Zealand

Workwise, a non-government organisation within the Wise Group, has been providing evidence-based employment services for people with experience of mental health conditions for more than 10 years.

Employment consultants are integrated with 52 multi-disciplinary mental health teams across six regions. During the last contract year Workwise has provided services for 1,988 people with around 40 per cent of these people supported in work at any point in time. Also in that year, Workwise had 1,290 new people referred, secured 754

jobs with a third of those in positions over thirty hours a week and exited 244 people as they were settled in employment.

EBSE programmes are a good return on investment

In 2011, Workwise, funded by Mental Health Solutions, contracted PricewaterhouseCoopers (PwC) to conduct a return on investment (RoI) analysis in relation to the provision of evidence-based supported employment (EBSE) services in New Zealand.

The evaluation found that:

- ***That there are significant returns to the Crown from investing in EBSE services within secondary mental health services.***
- Based on a 50 per cent average outcome rate, for every $1 spent $1.11 would be returned in the first year alone to the Crown in terms of economic contribution and reduced welfare benefits payments.
- In addition to this, every $1 spent from Vote Health would be returned in full within the first year through reduced contact time with mental health teams, and reduced admissions and length of stays in inpatient services.

These findings were based on analysis of data on 1,400 individuals who were referred to Workwise over a four year period and the costs of delivering the evidence-based programme in New Zealand. Health savings were calculated based on a case study provided by Hawkes Bay DHB which showed significant reductions in contact time and time in hospital for people who had an employment experience over a two-year period.

Working together

By implementing evidence-based employment services across New Zealand there is a real and measurable opportunity to reduce the incidence of long term unemployment, particularly as this group are at risk of becoming beneficiaries at a young age.

By working together, with both Health and Welfare, we can address the issues and inform joint funding, service and reporting frameworks to enable the effective national implementation of evidence-based employment services.

References

[i] OECD Organisation for Economic Cooperation and Development (2003). *Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People.* Paris: OECD.

[ii] Beynon. P. & Tucker. S. (2006). Ill health, disability, benefit and work: A summary of recent research. *Social Policy Journal of NZ.* 29.

[iii] Statistics New Zealand (2008). *Disability and the Labour Market in New Zealand in 2006.* Wellington: Statistics New Zealand.

[iv] Secker, J., Grove. B. & Seebohm, P. (2001). Challenging barriers to employment, training and education for mental health service users: the service user's perspective. *Journal of Mental Health* **10** (4) 395-404.

[v] Welsh, B. (2010). *Co-production in health management : an evaluation of Knowing the People Planning.* PhD Massey University, Palmerston North, New Zealand. Available at: http://muir.massey.ac.nz/handle/10179/1680. (Accessed on 22 Sept 2010).

[vi] Bond, G.R., Drake, R.E. & Becker, D.R. (2008). An update on randomised controlled trails of evidence-based supported employment. *Psychiatric Rehabilitation Journal* **31** 280-289.

[vii] Browne, D. & Waghorn. G. (2010). Early intervention in the Real World. Employment services as an early intervention for young people with a mental illness. *Early intervention in Psychiatry* **4** 327-335.

[viii] Sainsbury Centre for Mental Health (2009). *Briefing Paper 41. Commissioning what works: the economic and financial case for supported employment.* London: Centre for Mental Health.

[ix] Lockett, H. & Elwin, W. (2012). *Employment as a Health Intervention: A good return on investment.* Presentation at the Australasian Psychiatry Congress, Hobart 23 May 2012. Available at: www.tepou.co.nz/library/research/857. (Accessed on 5 June 2012).

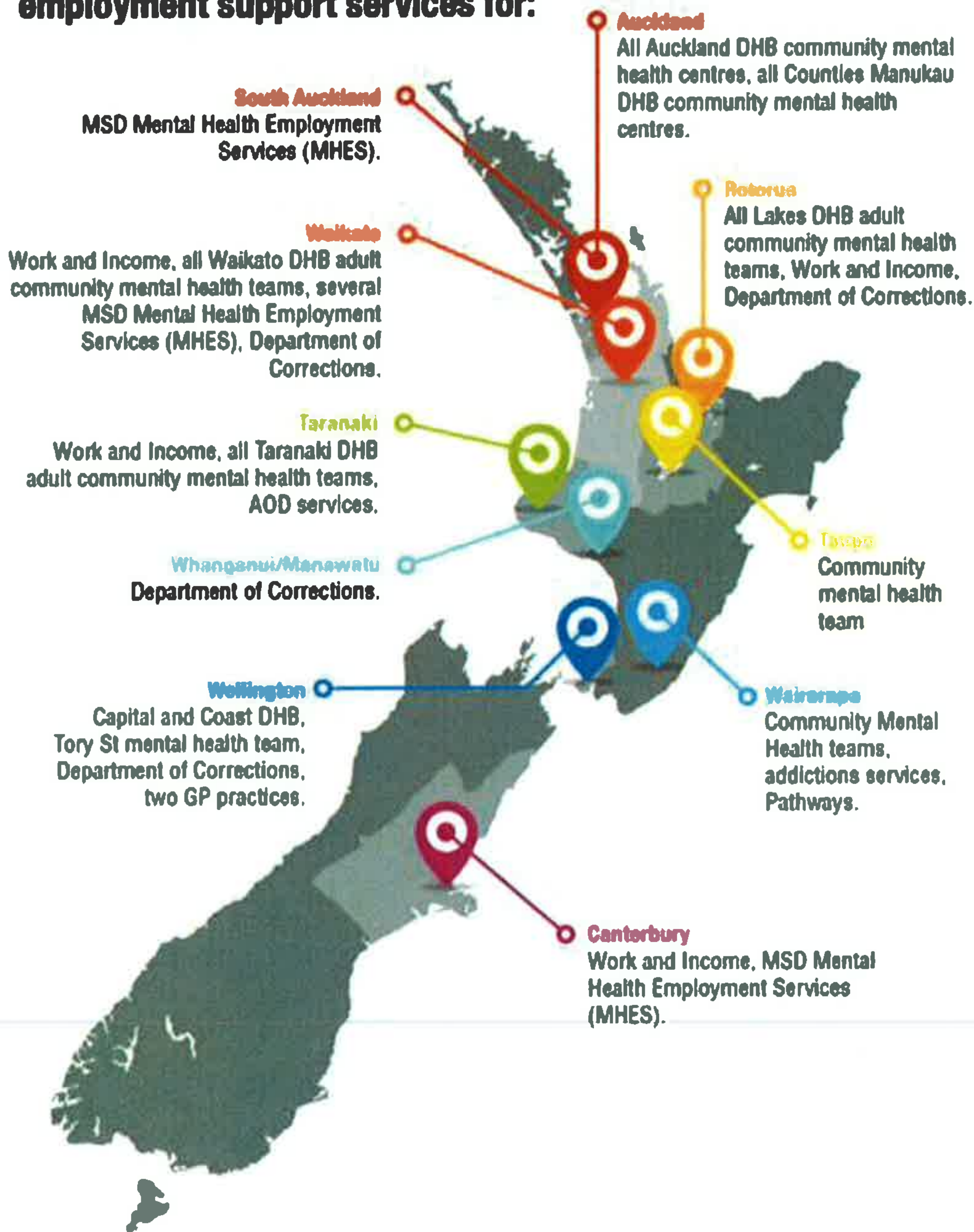
[x] Waddell G, Burton KA and Kendall N (2008) *Vocational rehabilitation. What works for whom and when?* London: TSO.

[xi] Shepherd G, Lockett H Grove B and Bacon J (2012) Establishing IPS in clinical teams – Some key themes from a national implementation programme. *Journal of Vocational Rehabilitation* 78 (1) 37-41.

workwise

employment agency

We provide integrated and other employment support services for:



ANZJP

Employment as a health intervention – the role of psychiatry in bridging the evidence to practice gap

Australian & New Zealand Journal of Psychiatry
47(5) 417–420
DOI: 10.1177/0004867412466594

© The Royal Australian and
New Zealand College of Psychiatrists 2012
Reprints and permissions:
sagepub.co.uk/journalsPermissions.nav

anp.sagepub.com

Helen Lockett[1] and Clive Bensemann[2]

Introduction

Employment is a central part of recovery for many patients, is generally good for mental health, and the evidence on how best to support people with a mental illness into jobs is well established. In Australia and New Zealand the employment rates of people with a mental illness remain extremely low, at less than 25% (Waghorn et al., 2012; Walsh, 2010) and employment support is not widely available as part of clinical practice. If evidence-based employment programmes were part of routine treatment at least 45% of people could be supported into employment and enabled to build careers (Drake et al., 2012).

This viewpoint provides a summary of the international research on the effectiveness of Individual Placement and Support (IPS) an approach to supported employment for people with a mental illness also referred to as evidence-based supported employment (EBSE). It describes the intervention and explores methods for its successful implementation. It argues that to address this evidence to practice gap a systematic implementation programme is needed across New Zealand and that psychiatrists and their professional bodies are well placed to influence and accelerate this implementation in publically funded mental health services. They can lead the development and delivery of employment-focused health services and influence public policy, funding and community expectations.

The science of supported employment

Data on the employment rates of people who are in contact with community mental health services is not routinely collected in New Zealand. However, Walsh (2010) was able to gather some data from audits conducted in eight District Health Boards which included information on employment status. From this, an average employment rate of 10% was estimated in 2004 increasing to just 17% in 2005. This figure compares with an employment rate of 45% for people across all disability groups and an employment rate of 77% at that time for the population without a disability (Statistics New Zealand, 2008). Aspirations however remain high as people see employment as a key part of their recovery (New Zealand Mental Health Commission, 2001).

Growing aspirations but continued low employment rates across developed countries has meant that methods of supported employment have been increasingly the focus of research, with more than 16 randomised controlled trials (RCTs) conducted internationally validating IPS supported employment. IPS takes a 'place then train' approach which helps people gain employment and then supports them in the job, against traditional vocational rehabilitation which focuses on pre-job training prior to employment placement, that is 'train then place'.

IPS employment services outperform traditional vocational services by nearly three times achieving 62% employment outcomes compared to 23% (Bond et al., 2008). Employment outcomes are defined as competitive jobs which are available to anyone in the labour market to apply for, have permanent status rather than temporary or time-limited, pay at least minimum wage and are not set aside for people with disabilities (with the exception of peer specialist roles). Around two-thirds of people who gain employment through IPS services work more than 20 hours per week and secure their first jobs ten weeks earlier than the controls (Bond et al., 2008). Longitudinal studies give evidence on job tenure. Two such studies, following people for 10 years, showed that more than half who secured employment through IPS programmes were employed for at least 50% of the ten years (Becker et al., 2007; Salyers et al., 2004).

In 2007, the results of the first European IPS RCT were published aiming to understand the application of the evidence outside North America. The trial was conducted in six countries and had tight inclusion criteria to ensure the profile of participants was consistent: people with experience of psychosis, extensive unemployment (greater than one

[1]The Wise Group, Hamilton, New Zealand
[2]Auckland District Health Board, Auckland, New Zealand

Corresponding author:
Helen Lockett, The Wise Group, PO Box 307, Hamilton, 3240, New Zealand.
Email: helen.lockett@wisegroup.co.nz

Table 1. The eight evidence-based principles of IPS.

1.	Competitive employment is the primary goal
2.	Everyone who wants it is eligible for employment support
3.	Job search is in line with individual preferences and strengths
4.	Job search is rapid – within four weeks
5.	Employment specialist and clinical teams work and are located together
6.	Support is time-unlimited and individualised to both the employee and the employer
7.	Welfare benefits counselling is available
8.	Job development with local employers

year) and who had experienced major role dysfunction for more than two years. IPS programmes outperformed the best available vocational services in each country, regardless of benefits systems or labour market conditions (Burns et al., 2007). The only factor which had a significant impact on the effect size was the local unemployment rate: as this went up the effect size reduced. The European study also examined the relationship between getting a job and going into hospital and, in contrast to concerns often held amongst clinical staff that employment can exacerbate a person's symptoms, concluded that '*going into employment does not make a person unwell*' (Burns et al., 2007).

The features of IPS and the fidelity scale

IPS is based on eight principles (Table 1) which all have their own underpinning evidence (Bond, 2004). The closer a supported employment programme aligns itself to these principles the better the outcomes achieved (Bond et al., 2008) (Table 1).

As with other evidence-based practices (EBPs), a standardised fidelity scale has been developed from the research. The supported employment scale consists of 25 items related to the key components of the practice. The use of a scale in this way for a psychosocial intervention contrasts with other interventions, such as cognitive behavioural therapy, where no fidelity scale is yet developed.

The importance of fidelity scales is illustrated in a recent RCT conducted in England which found no difference in outcomes between the control and the supported employment intervention group (Howard et al., 2010). Measurement against the scale based on descriptions provided by the authors indicated that the failure to demonstrate difference between groups was most likely due to poor programme implementation including, for example, the low intensity of the service and the lack of governance arrangement between the mental health and employment service agencies.

Adherence to the fidelity scale helps ensure the employment programme is patient centred and individually tailored. It involves integrating employment support into mental health treatment through the location of an employment specialist within a multi-disciplinary team. The employment specialist is either employed by the publically funded health service or by an external employment service provider, such as a Non-Government Organisation (NGO). Through this approach employment becomes an integral part of the care plan and is offered to everyone who is receiving treatment from the clinical team and who has an interest in gaining a job.

The importance of referring all motivated patients to employment specialists without applying explicit or implicit exclusion criteria is crucial as individual characteristics such as age, gender, race, education, marital and housing status, diagnosis and symptoms including substance dependence do not predict who will or will not get and keep a job (Campbell et al., 2009).

Cost-effectiveness and resource allocation

Larger trials following people over more than two years are needed to better understand the cost-effectiveness of IPS programmes, however, there is some emerging evidence. In the United States Drake et al. (2010) suggested that given the returns from reduced welfare benefits payments, increased taxes and decreased use of mental health services, investment in IPS programmes could be at little or no cost to government. The European RCT also found that use of community mental health services and hospital admission rates reduce when people gain employment (Burns et al., 2007).

In the current fiscal environment resource allocation away from treatments or interventions which are less effective relative to their costs is key to increasing access to EBPs. A Canadian study estimated that supported employment could be funded across the province of Quebec for everyone who is likely to need it for half the cost of what was currently being invested in less effective or ineffective services (Latimer et al., 2011).

Addressing the science to practice gap

The very low employment rates of people with a mental illness provide the moral imperative for action, to make employment support services in line with the principles of IPS a routine part of mental health services in

New Zealand. For many years the country has funded supported employment services which are separate from mental health services. This is largely as a result of the fact that funding for employment services can be sourced from two government departments, the Ministry of Social Development (MSD) and the Ministry of Health, and there is no agreement on whose core business it is. There is a lack of policy guidance and common funding methods meaning that the decisions on whether and how to fund and deliver services in line with the evidence base rest with local planners and funders. Service providers therefore remain vulnerable to personnel changes and local funding choices.

Despite this, IPS programmes do exist in parts of New Zealand which show the real-world application of the efficacy trials (Waghorn et al., 2011; Porteous and Waghorn, 2009). Effective implementation has involved on-site leadership to help overcome organisational and cultural barriers to enable both the employment and the mental health service to function as one integrated service to the benefit of individual patients. In one site this also involved converting an existing clinical role, an occupational therapist position, into an employment specialist post.

A key aspect of IPS programmes is that mental health services view assistance towards recovery and social inclusion as part of their core business and acknowledge that case management alone will not achieve this. Once accepted, employment support is offered routinely as part of an integrated treatment package. For many clinicians, this can challenge their professional training and clinical experience. It takes time, commitment to full integration and most importantly demonstrations of success to bring about the change in attitudes and culture needed to maximise the impact of the employment specialist within the clinical team (Shepherd et al., 2012).

A systematic implementation programme is needed in New Zealand to move beyond the early stages of implementation to sustained implementation. Key components of this programme need to be identified based on the available evidence from other countries and then tested to understand local effectiveness. The development nationally of early intervention services in New Zealand more than a decade ago illustrates the feasibility of relatively quickly translating new evidence and models of care into day to day service delivery if a national perspective is taken.

The United States has the 'Johnson and Johnson - Dartmouth Community Mental Health Programme', a systematic programme of IPS implementation with technical support provided across 13 states. A smaller implementation programme is available in the UK through the Centre for Mental Health. Both the US and UK programmes are committed to bridging the science to practice gap. They regularly conduct fidelity reviews to check practice against the evidence base and feed this back to practitioners for service improvement. This is an approach which is consistent with the evidence from implementation science (Fixsen et al., 2005) and needs to be more thoroughly applied in New Zealand.

Employment-focused mental health services

The New Zealand Minister of Health has signalled a desire for clinical leadership in health service planning and delivery, as well as the need for savings through service efficiencies (Ministry of Health, 2012). The evidence is clear that health services must be delivered in parallel with, not sequentially with, vocational services and people do not have to be symptom free before returning to work (Shepherd et al., 2012).

Employment-focused healthcare is a term that is used in the vocational rehabilitation literature across all health conditions. Psychiatry and psychiatrists have an opportunity to advocate, educate and lead in this area. What would this look like in psychiatry? It is important for psychiatrists to familiarise themselves with the evidence that now exists about the efficacy of employment interventions and to incorporate this in their approach to patient care. Knowledge of a patient's circumstances and their aspiration for meaningful employment should be as central to care as knowledge about their family/whānau, social supports and living situation. These issues are a core part of a patient's wellbeing and recovery just as they are to all members of the community. At an individual physician level conversations about working life and aspirations to work should be part of routine consultations. Clinicians are critical carriers of hope in relation to return to work and need to ensure they don't perpetuate a negative cycle of hopelessness (Marwaha et al., 2008). Despite the evidence and the aspirations of patients clinicians may have misperceptions that employment and employment programmes are a barrier to recovery. A series of self reflective questions could address these perceptions – 'Am I aware of how competitive employment contributes to recovery?' and 'do I believe that competitive employment is feasible for clients with severe and persistent mental illnesses?' Along with questions directed to patients about whether they are working, would like to work and what help the clinician can offer them with this.

Professional bodies such as the Royal Australian and New Zealand College of Psychiatrists are well placed to play an important role in influencing public policy and community expectations about the need for effective employment interventions as part of mental health treatment. The College can advocate that government policy and national planning should include reference to this aspect of integrated mental health

service delivery and guide funders and planners on its importance and the fact that national, regional and local measures of health systems performance should use indicators of role functioning and social inclusion, including employment. Supporting people to remain in or return to work is an important clinical outcome of the treatment of patients of working age and should be a health key performance indicator. Furthermore, college training and continuing education of psychiatrists should include familiarisation with the evidence on employment and mental health.

Conclusion

People who experience a mental illness want to work and there is now good evidence on the best approach to supporting patients to secure and sustain jobs. IPS is a proven psychosocial intervention which translates across countries and into real-world mental health services. It is effective and looks to be cost effective or at least cost-neutral. Other countries are testing methods to improve and embed implementation but as yet there is no proven method for implementing IPS on a larger scale in Australia and New Zealand. The low employment rates of people with a mental illness combined with the evidence provide a strong moral obligation and an opportunity for psychiatry, for the College and for psychiatrists to take a lead in adapting practice to the evidence, in the education of psychiatrists and by influencing national and regional policy, funding and planning so as to identify and test methods of implementation which will bring this evidence into routine clinical practice.

Acknowledgements

The authors would like to thank the peer reviewers for their constructive and valuable comments.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

References

Becker DR, Whitley R, Bailey EL, et al. (2007) Long term employment outcomes of supported employment for people with severe mental illness. *Psychiatric Services* 58: 922–928.

Bond GR (2004) Supported employment evidence for an evidence-based practice. *Psychiatric Rehabilitation Journal* 27: 345–359.

Bond GR, Drake RE and Becker DR (2008) An update on randomised controlled trials of evidence-based supported employment. *Psychiatric Rehabilitation Journal* 31: 280–290.

Burns T, Catty J, Becker T, et al. (2007) The effectiveness of supported employment for people with severe mental illness: A randomised controlled trial. *The Lancet* 370: 1146–1152.

Campbell K, Bond GR and Drake RE (2009) Who benefits for supported employment: A meta-analytic study. *Schizophrenia Bulletin* DOI:10.1093/schbul/sbp066.

Drake RE, Bond GR and Becker DR (2012) *Individual Placement and Support: an Evidence-Based Approach to Supported Employment*. New York: Oxford University Press.

Drake RE, Skinner JS, Bond GR, et al. (2010) Social Security and mental illness: Reducing disability with supported employment. *Health Affairs* 28: 761–770.

Fixsen DL, Naoom SF, Blase KA, et al. (2005) *Implementation Research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Howard LM, Heslin M, Leese M, et al. (2010) Supported employment: randomised controlled trial. *The British Journal of Psychiatry* 196: 404–411.

Latimer E, Bond GR and Drake RE (2011) Economic approaches to improving access to evidence-based and recovery-oriented services for people with severe mental illness. *Canadian Journal of Psychiatry* 56: 523–529.

Marwaha S, Balachandra S and Johnson S (2008) Clinicians' attitudes to the employment of people with psychosis. *Social Psychiatry and Psychiatric Epidemiology* 44: 349–360.

Ministry of Health (2012) *Briefing to the Incoming Minister of Health*. Wellington: Ministry of Health.

New Zealand Mental Health Commission (2001) *Employment checklists for health, employment, education and income sectors*. Wellington: Mental Health Commission.

Porteous N and Waghorn G (2009) Developing evidence-based supported employment services for young adults receiving public mental health services. *New Zealand Journal of Occupational Therapy* 56: 34–39.

Salyers MP, Becker DR, Drake RE, et al. (2004) Ten-year follow-up of clients in a supported employment program. *Psychiatric Services* 55: 302–308.

Shepherd G, Lockett H, Grove B, et al. (2012) Establishing IPS in clinical teams – Some key themes from a national implementation programme. *Journal of Vocational Rehabilitation* 78: 37–41.

Statistics New Zealand (2008) *Disability and the Labour Market in New Zealand in 2006*. Wellington: Statistics New Zealand.

Waghorn G, Saha S, Harvey C, et al. (2012) Earning and learning in people with psychotic disorders. Results from Australia's second survey of psychotic disorders. *Australian and New Zealand Journal of Psychiatry* 46: 774–785.

Waghorn G, Stephenson A and Browne D (2011) The importance of service integration in developing effective employment services for people with severe mental health conditions. *British Journal of Occupational Therapy* 74: 339–347.

Walsh B (2010) *Co-production in health management: an evaluation of Knowing the People Planning*. PhD thesis, Massey University, Palmerston North, New Zealand. Available at: www.muir.massey.ac.nz/handle/10179/1680 (accessed 22 September 2010).