International IPS Learning Community

Deborah R. Becker, Robert E. Drake, and Gary R. Bond

The International IPS Learning Community grew out of an annual philanthropic gift from Corporate Contributions Johnson & Johnson. The goal of the project was to assist people with severe mental illness who are interested in competitive employment by implementing and disseminating IPS supported employment. Its initial focus was in the United States, but later it expanded to other countries. The program was called the Johnson & Johnson - Dartmouth Community Mental Health Program, starting with one site in each of three states in 2001. The foundation of the program is the partnership between mental health and vocational rehabilitation agencies at the state level that matched initial incentive funding. The Johnson & Johnson annual gift assisted 16 states and 3 other countries with IPS start-up. Since Johnson & Johnson discontinued their annual gift, 8 states and 3 other countries have joined without the incentive funding.

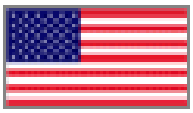
The IPS Employment Center (formerly known as the Dartmouth Psychiatric Research Center) partners with state/country mental health and vocational rehabilitation leaders to develop the infrastructure for program implementation, including plans for funding, training, monitoring program implementation (fidelity) and tracking outcomes. After state leaders began to collaborate, they agreed to form a structured learning community based on learning collaborative models. The IPS Employment Center oversees the program by providing technical assistance and consultation, developing training and educational materials, conducting online and in-person courses for stakeholders, offering research opportunities, and convening stakeholders on conference calls and in-person meetings. The IPS Center provides a web-based data tracking portal in which all sites enter simple quarterly employment and education data. The Center analyzes the data and sends graphs and tables back to the sites and state leaders, allowing them to compare outcomes. The International IPS Learning Community organizes committees and work groups that have regular conference calls to develop educational and training materials, share experiences, policies and procedures, and develop advocacy and marketing plans. These materials help with the expansion and sustainment of IPS services.

Following the example of other successful learning collaboratives, we hold an annual two-day in-person meeting of the International IPS Learning Community to convene IPS leaders, consumer and family leaders, host a few keynote speakers, provide research updates, and share information and experiences in discussion groups. States and countries have replicated the learning community structure within their own states/countries, and have annual meetings.

In summary, the IPS Learning Community emphasizes collection and monitoring of employment/education outcomes and program implementation, regular communication among

stakeholders, sharing of ideas and information, provision of training and technical assistance, and commitment to research and innovation. The International IPS Learning Community currently includes 24 states/jurisdictions and six other countries.

Growth of IPS in the United States of America (USA)



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IPS (Individual Placement and Support) is the evidence-based approach to supported employment that was developed in the United States in the late 1980s originally for people with serious mental illness. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that only 2% of people with severe mental illness have access to effective employment services while over 60% express an interest in employment and less than 20% are employed. IPS began in several preliminary studies and randomized controlled trials in the 1990s and moved into routine mental health center settings in the early 2000s. Documented by two national surveys, in 2016 over 500 IPS programs existed in 38 states and in 2019 over 850 IPS programs in 41 states. A 2014 study of 129 active IPS programs in 13 states found that 96% were sustained over a two-year period.

The United States has 50 state mental health authorities that function autonomously, setting policy and direction for mental health and employment services within each state. Consequently, the trajectory of IPS dissemination from start up to wide-scale adoption has varied widely across states. Federal efforts also promote IPS. For example, SAMHSA provides grant funding to implement and disseminate IPS services. Several factors continue to challenge the expansion of IPS in the United States. The lack of a single dedicated funding stream requires states to blend funding from multiple sources (e.g., state mental health funding, state Vocational Rehabilitation funding, Medicaid, and grant funding) to pay for IPS services. In addition, mental health clinicians and families have not set competitive employment as a clear priority the way people with mental health disorders have. Despite these challenges, IPS continues to spread.

The International IPS Learning Community provides a clear strategy for IPS implementation, dissemination and expansion. Twenty-four states have joined this broad network and used it to guide the expansion of IPS.

IPS in Canada

Eric Latimer

In Canada, the 10 provincial and 3 territorial governments assume, with limited exceptions and qualifications, responsibility for funding, organizing and delivering health and social services in their respective provinces. These responsibilities include most social assistance, employment and other programs for people with disabilities. Accordingly, adoption of programs such as IPS typically depends on decisions taken by provincial governments, lower-level jurisdictions such as regional health authorities, or even individual hospitals or other local organizations. .

Programs that explicitly identify as IPS and that have striven to attain a good or better level of fidelity to the model have existed since the early 2000s, as a result of entirely independent decision-making processes, in two very different provinces: British Columbia (Oldman et al., 2005) and Québec (Latimer et al., 2006). To date, implementation of IPS remains very limited in each of these two provinces, being mostly concentrated in the Vancouver area in the case of British Columbia (Latimer et al., 2019) and, to the author's knowledge, in two urban and one rural site in Québec. The regional health authority that oversees the one program in Montreal (the Montreal West-Island Integrated University Health and Social Services Centre) joined the IPS International learning community in 2018. It remains, as of this writing, the only Canadian jurisdiction to have done so.

Unusually, and at the prompting of a major non-profit mental health service provider in Toronto, the federal government funded, in 2015, a multi-province supported employment program. This program, called At Work/Au travail, funded the development or enhancement of supported employment programs in 12 Canadian Mental Health Association sites located in 7 Canadian provinces. Although this program funded the implementation of programs aiming to help individuals with mental illness obtain competitive jobs, it was not structured to promote the implementation of high-fidelity IPS [3]. As of this writing, most of the sites continue to be funded but it is unclear to what extent they conform to the IPS model.

In conclusion, IPS implementation in Canada remains extremely limited. Provincial responsibility for programs of this nature, combined with provincial governments having given priority to other programs for people with mental illness, has meant that implementation of IPS has arisen almost exclusively from local initiatives.

The growth of IPS in the UK

Jan Hutchinson and Lynne Miller

IPS was introduced in the UK in the early 2000s, and was initiated by individual mental health NHS Trusts. In order to raise the profile of IPS the Centre for Mental Health, a national charity has provided implementation support, and since 2005 has recognised 18 IPS providers as Centres of Excellence across England. In addition the Centre has developed a training programme for Employment Specialists, and consultancy support. The IPS approach has also been applied in the UK for different client groups including people with a history of addictions, and people with common mental health problems.

In 2016 NHS England made a significant commitment to expand access to IPS for people using secondary mental health services by including IPS in the 5 year forward view. An initial benchmarking exercise was completed which identified that 10,000 people from secondary mental health services were accessing IPS services, a commitment was made to double access to 20,000 by 2022 . Following on from this a further commitment was made to continue the expansion, which was included in the NHS England mental health Long-term plan. This sets a goal of expanding access to IPS in secondary mental health services to 55,000 people by 2023/24, and 115,000 by 2028/29 (which equates to 50% of the secondary care mental health population). In addition a range of large scale clinical trials have taken place across the UK to test out IPS in an addiction setting and in primary care.

It is estimated that there are currently approximately 400 ES and 60 Team Leaders working across England, and that this will need to expand to 1300 ES and 240 Team Leaders by 2024; with a further expansion by 2028. It is also increasingly recognised that an expansion of senior IPS Leadership posts will be required to ensure that services are well led, and the change management and cultural changes required are achieved within health trusts.

In order to ensure that more people in the UK are able to **achieve job outcomes through the growth of consistently high quality IPS services**, NHS England and the Joint Work and Health Unit have invested in a comprehensive support programme which began in 2018/19 and will continue throughout 2020/21.

The support offer focuses on 3 different areas of activity:

1. **Hands-on implementation support** from a network of IPS experts;
2. A **workforce development programme** to support recruitment and training of IPS staff;
3. Developing, cascading and embedding **tools to facilitate effective reporting, monitoring and evaluation** of the support provided by IPS services.

Following a competitive tendering process, Social Finance were awarded the contract and work began in January 2019 to implement **IPS Grow,** a consortium of partners.

England joined the international IPS learning community in 2019. We very much wish to strengthen our relationship and learning with international partners via participating in the USA calls, and both IPS Grow/Centre for Mental Health are involved in organising a European IPS conference in 2022. A date has been set for the first conference for March 2020 in Iceland.

IPS IN ITALY IS COMING OF AGE

Angelo Fioritti and Denise Manchisi

EQOLISE, the first European trial of the effectiveness of IPS included the Italian site of Rimini. The study was planned in 2001 and replicated the excellent results of American studies, despite the extensive differences in labor market regulations, organization and culture of mental health services. Quite unexpectedly, IPS in Rimini was more effective than in Northern European countries participating in the study, possibly because of a high motivation to work in a country with low unemployment and disability benefits. After EQOLISE, IPS continued to be practiced in Rimini and since then more than 350 users have received IPS services, with employment rates of about 45%.

From Rimini, IPS spread to the whole Region Emilia-Romagna (about 4,5 million inhabitants in Northern Italy), whose Council put IPS in its policy in 2008 and financed a program for its implementation in all Community Mental Health Centers (CMHCs), mission accomplished in 2018 when all 41 CMHCs were able to provide IPS to their users. By March 31st 2019, 668 users were in IPS and 340 of them were working in the competitive labor market. In 2017 IPS started to be offered also to users of drug addiction centers and in 2019 a new program on IPS to adolescent and young adults with transition problems has started.

The IPS Emilia-Romagna regional team has also actively trained staff from pilot CMHCs located in eight other regions (Lombardy, Veneto, Liguria, Friuli-Venezia Giulia, Marche, Lazio, Sicilia, and Tuscany). These centers have created a network that holds an annual national meeting since 2015, organized by the professional association of IPS workers IPSILON. The meeting of 2017 was introduced by a speech of the Minister of Labor Giuliano Poletti. All Italian sites are actively involved in and supported by the "IPS International Learning Community" coordinated by Deborah Becker, a unique opportunity for professional improvement and personal growth. The IPS Italian Community is particularly grateful to Sandy Reese for her field work in training, supervision and start-up of fidelity check.

As IPS is coming of age in Italy, we can say that it is expressing its full ethical, technical and practical potential.

IPS in Spain

Débora Koatz, Pilar Hilarión, and Rose Suñol

Back in 2013, IPS pilot project started in Spain with an agreement among three Regional Government Departments at Catalonia (Ministry of Health, Ministry of Business and Labor, and Ministry of Social Wellbeing and Family), "la Caixa" Banking Foundation, Government of Province of Barcelona, and the IPS Employment Center. The goal was to improve labour and social inclusion of people with severe mental illness, in a pilot project that aims to integrate efforts and workflow from three areas (health care, social services and employment) both at community and policy levels to develop IPS supported employment programs.

From October 2013 up to December 2017, 7 sites in 3 regions have adapted their own programs to implement IPS, with an average of 435 clients participating in the programs quarterly, and an average of 20 Employment Specialists.

Changes implemented were based on a specific patient management system including integration of Employment Services (ES) with Mental Health treatment teams. ES involve employers in an active way, by getting close collaborations through a win-win goal. Services were measured by external evaluation through the IPS Fidelity Scale every 6 month up to reach good fidelity.

Actions taken: 1) Professional training and technical assistance; 2) Improving integration between mental health treatment teams and employment services (ex: periodic meetings, patient plans and training on benefits planning); 3) On-site support and monitoring achievements through an ICT platform; 4) Quarterly follow-up meetings among regional leaders, mental health teams and employment services; 5) Action plans developed in each employment service.

As a result of this pilot project, and despite the severe economic crisis, the percentage of working people have increased almost three-fold from the beginning of the program (15% - 43%). Scores in fidelity reviews have improved 33,5% in average and 1,188 jobs were covered.

Main barriers included managing information between three different departments of government, conflicts with existing budgets for sheltered work, social and cultural assumptions regarding stigma and mental illness.

In the other hand, this pilot project fostered evidence-based job placement programs with a strong local leadership and commitment, focusing on participants' recovery and highlighting the IPS intervention in Spain as an effective intervention to help people with a mental health condition obtain and maintain competitive employment. Stakeholders' support and government recognition of IPS model may foster IPS expansion in the near future.

Isqua: https://academic.oup.com/intqhc/article/29/suppl_1/60/4237841

International Journal of Integrated Care: https://www.ijic.org/articles/abstract/10.5334/ijic.2755/

Avedis Donabedian Research Institute

https://www.fadq.org/portfolio/proyecto-piloto-metodologia-ips-en-cataluna/ (Spanish)

Individual Placement and Support in the Netherlands

Cris Bergmans, Lars de Winter and Jaap van Weeghel

IPS was introduced in 2003 in the Netherlands in four Dutch Mental Health Organisations. Implementation was carried out with a feasibility study in the Netherlands. This study showed that IPS was feasible in the Netherlands if some important preconditions, such as new attitudes and expectations regarding clients' recovery, a new organizational structure, extensive training, and new mechanisms of financing (van Erp et al., 2007), were met.

As the next step, we started conducting an all-Dutch multisite RCT in 2005 at four IPS sites. Within a follow-up of 30 months, 44% of the participants in the IPS condition obtained competitive employment versus 25% in the condition entailing vocational support as usual (Michon et al., 2014). Nowadays, IPS is cited as a recommended intervention in various treatment standards for diverse mental illnesses and implemented on a national scale throughout the Netherlands in 33 mental health organisations. This implementation on a national scale was achievedby assessing program fidelity for all mental health organizations every two years and by collecting outcome data every three months (van Weeghel et al., 2019).

In the period from 2014-2019 the number of IPS-programs increased from five mental health organisations in 2014 to 33 at the end of 2019 implementing IPS throughout the Netherlands. The total number of clients receiving IPS increased from 1,410 clients receiving IPS in 2016 to 3,674 clients receiving IPS in 2018. The average employment rate of the Dutch IPS programs from 2016 to 2019 is 30.52%,with increasing levels of employment rate after multiple years of implementation of IPS within the IPS program (i.e. an average employment rate of 26.64% in the first year and 37.07% in fourth year after implementing IPS). At the end of 2019 a total number of 209 IPS employment specialists (on average 8.71 per IPS program) carried out IPS.

An important condition for the rise of IPS in the Netherlands is a national financial incentive by means of funding IPS for beneficiaries of the Employee Insurance Agency (Dutch abbreviation: UWV; Uitvoeringsinstituut Werknemers Verzekeringen). Also health care insurance companies see the importance of employment for the health outcomes of their clients and fund the initial start of IPS trajectories for a lot of IPS programs (van Weeghel et al., 2019).

Since 2008 a national center of expertise for severe mental illness (Phrenos) has been responsible for the national coordination and registration of IPS implementation programs and the training of IPS workers. Fidelity reviews are done every 2 years by a team of seven trained reviewers from Phrenos. From all the Dutch IPS programs 65.38% have at least a good fidelity (mean fidelity score for all IPS programs = 102.27)

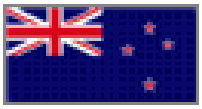
The Netherlands joined the International IPS learning community in 2012. Since then every year a delegation from the Netherlands joined the annual IPS meetings.

IPS is a dynamic model that offers time and again new adaptations and extensions (Mueser et al., 2016). The driving force behind this is the ambition to make IPS even more effective for even more people. This ambition is driving IPS proponents in the Netherlands to start expanding our IPS practice in terms of target groups, types of providers, goals, and added interventions.

On the first of May 2019 a new ministerial regulation started to make Individual Placement and Support (IPS) also available for people with Common Mental Disorders (CMD). A limited subsidy will be available for 200 IPS-trajectories for this new target group. Persons on social welfare and under responsibility from municipalities can also be eligible for an IPS-trajectory under this new regulation.

Individual Placement and Support in Aotearoa New Zealand

Helen Lockett, Warren Elwin, and Becki Priest



IPS employment program delivery in Aotearoa NZ began in 2001. Initial developments were led by local champions from within non-government employment support services and government mental health services, rather than mandated from central government. The result of this local leadership means that IPS employment programs are well-established and operating to high fidelity in some health regions, and completely lacking in others.

As of September 2019, there are 53 full-time equivalent employment consultants working across 12 of 20 health regions. With the size of program varying from one full-time employment consultant to 13 employment consultants in one region. Access is therefore patchy and inequitable.

To date, IPS employment support programs have largely been funded through regional mental health funding with some philanthropic funding. A 2017 review of the policy opportunities and barriers to IPS employment program implementation in Aotearoa NZ found that current government policy and contracting were inhibiting rather than enabling the availability of IPS programs (Lockett, Waghorn, & Kydd, 2018).

Since 2015, dedicated technical assistance, through specialist IPS implementation managers have been working with local clinical and employment support teams to improve the fidelity and outcomes of IPS programs. Technical assistance is part-funded centrally, from the Ministry of Health and part-funded through the local health services. Evaluation of the 2015-2016 implementation manager pilot found that technical assistance improves program reach, particularly to people with a diagnosis of psychosis, and increases fidelity to IPS principles (Te Pou o te Whakaaro Nui, 2016, 2017). The evaluation also found that clinicians valued the integrated employment support, more clinicians instigated work-focused conversations as part of routine health treatment, and clinicians referred more people on their caseload to the employment consultant.

In 2018, the Ministry of Social Development funded two IPS prototypes. These have been evaluated. The prototype in Waitematā on the North Island, achieved a high level of integration between employment and mental health services, clinicians' perceptions of the IPS employment program and of changes in the people who received IPS were overwhelmingly positive. The evaluation found that IPS aligned with a kaupapa Māori approach to mental health service delivery. Both prototypes have been extended to a three-year trial, with the Waitematā IPS protype expanded from two FTE employment consultants to eight.

Aotearoa New Zealand joined the International IPS Learning Community in December 2016, and at the same time established a Centre of Expertise for IPS implementation (Work Counts) and an IPS

national steering group. The steering group is made up of representatives from the Health and the Social Development Ministries, the regional health clinical directors and general managers, planners and funders, non-government employment support providers, and lived experience and cultural leaders. Each year since 2016, representatives of the IPS steering group have attended the International IPS learning community meeting in the USA.

Recent expansion of implementation to kaupapa Māori mental health and addiction services, along with a new IPS employment program in Dargaville, Northland, demonstrate that the IPS approach is flexible enough to be able to be led by the cultural needs of the local population. Cultural leadership and attention to culture are both important components of effective implementation of IPS employment programs in Aotearoa New Zealand (Priest & Lockett, 2019).

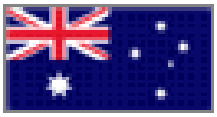
In 2019, the government announced a major investment in and commitment to transforming mental health and addiction services. This followed the publication of He Ara Oranga, the report from the Inquiry into mental health and addiction services and the OECD mental health and work: New Zealand report. Both reports signal an opportunity to expand IPS, so that specialist employment support becomes a core part of mental health and addiction services across the country.

To respond to these recommendations, the IPS national steering group is currently developing and costing a five-year IPS scale-up implementation plan. The proposed plan includes a year on year increase in the number of IPS programs, with priority given to regions with no IPS programs, and regions with high numbers of young people, and Māori and Pasifika people. The plan also includes the provision of implementation support and regular fidelity reviews, lived experience and cultural leadership, and the development of an Aotearoa NZ community of practice.

Exciting times lie ahead.

IPS in Australia

Eóin Killackey and Gina Chinnery



Since 2005 when IPS was first implemented in Australia, two approaches to implementing IPS have developed. The first is direct employment of IPS workers by a health service. The second is a partnership model between health services and government funded employment services. The former model has tended to be used in the youth mental health area, and the latter in adult mental health services. In Children and Adolescent Mental Health Services and Adult Mental Health Sservices inpatient and outpatient services are funded by the State and Territory Governments. However, headspace, a primary mental health service for young people aged 12 – 25 years with mental health issues, is directly funded by the Federal Government. The federal government is also responsible for welfare payments including the disability support pension.

The number of sites providing headspace has grown since 2005. A recent paper [1] summarises the current state of IPS implementation in Australia. At the time of publication there were 87.6 full time equivalent IPS workers working across 36 sites. 14 of the sites in that paper where headspace sites participating in a trial of headspace funded by the federal Department of Social Services (DSS). Since July 2019 that trial has been extended and expanded to 10 more headspace sites so that IPS would now be operating at 46 sites with approximately 108 full time equivalent positions.

Training, support and fidelity measurement for the headspace/DSS trial has been contracted to IPSWorks, a unit of the Western Australian Association for Mental Health. IPS Works also provides technical support and consultancy for a number of other sites around the country which are implementing or thinking of implementing IPS. Orygen, Australia's youth mental health research and advocacy agency, as well as headspace National (the national co-ordinating office of headspace) also provide training and support to youth mental health services interested in or implementing IPS.

With regards to the future of IPS in Australia there is currently a significant amount of positive momentum building. The federal government requested that the Productivity Commission inquire into mental health in 2019. The commission recently released its 1500 page interim report. One of the recommendations of the interim report is "The Individual Placement and Support (IPS) model of employment support should be extended beyond its current limited application through a staged rollout to (potentially) all State and Territory Government community mental health services, involving co-location of IPS employment support services" (Recommendation 14.3)[2].

Further the evaluation first stage of the DSS/headspace IPS trial conducted by KPMG was released last week. Speaking as she launched it Minister for Social Services Ann Ruston stated "*Of the 1558 trial participants, more than 40 per cent found employment or participated in education while a*

further 20 per cent continued to take part in the program. The data showed that participants who entered the program who were on Newstart [Australia's unemployment support payment] *had the highest level of employment success with almost 60% moving into a job. Also pleasing was the fact that one in three young people on the program who were receiving the Disability Support Pension found a job. Those participating in the Trial said several key elements made their experience with the trial positive.*

Elements that were particularly valued include:

- *The time-unlimited support*
- *The individualised and tailored support*
- *And the fact that the program focused on their personal goals, interests and strengths"*

(Full transcript of the speech available at: https://ministers.dss.gov.au/speeches/5321)

The Victorian State Government launched a Royal Commission into the Victorian Mental Health System which will report in 2020 and it is anticipated will lead to widespread change in the system with new funding and a greater focus on holistic care, including vocational, recovery.

So there is much to be optimistic about currently. The main challenges ahead are:

1. Finding a mechanism to sustainably fund IPS in state funded mental health settings.
2. Developing a skilled IPS workforce who are trained in the model and embrace the philosophy of recovery behind it.
3. Creating a career structure for IPS workers to ensure that they stay engaged in this field and can progress within it as their own skills develop.

Resources to read more:

https://www.orygen.org.au/Research/Research-Areas/Functional-Recovery

https://www.dss.gov.au/mental-health-programs-services/individual-placement-and-support-ips-trial

http://ipsworks.waamh.org.au