# Tips for a successful IPS service

*Note: This tool forms part of a suite of guidance documents, tools and templates developed by the IPS Grow consortium. It should be read in conjunction with document "2.0 Introduction to IPS Grow delivery tools". Further information can be found at www.ipsgrow.org.uk. This tool was last updated June 2018.*

In order to manage referral volumes from clinicians within secondary mental health services, employment services should consider doing some or all of the following:

- Integrate employment services with clinical teams where possible – employed by the service and part of the service. An intersectoral team approach is the next best option and co-operation for full integration is required.

- Employment Specialists must sit and be fully integrated with the clinical teams, attend relevant case meetings, and be available to discuss referrals in real time. The emphasis should be on a multi-disciplinary approach to the return to work. Clinical teams have an important role to play in both encouraging and empowering people to explore work opportunities, and increasing confidence and self-belief. In addition, providing clinical interventions to support the return to work process in partnership with the ES, such as medication reviews, supporting the management of risk and safety issues, and supporting individuals to manage their mental health condition at work.

- Recruit Employment Specialists (ES) with the right qualities/attributes, including: tenacity, focus, commitment, excellent communication, organisational skills and target driven. ES's need to be able to engage and motivate service users, work well within a clinical team, and be able to develop effective relationships with employers to secure tailored job opportunities.

- Gain senior leadership, middle manager and clinical lead buy-in and clear commitment from the beginning – create regular review meetings with these senior staff and a willingness to engage and problem solve.

- Managers must be involved in the service model implementation and monitoring of activity and quality.

- Allow 2-3 week lead time to gain attendance at meetings as most senior clinical staff will have diaries booked up in advance.

- Operational review meetings need to be regular and strategic relative to business plans of host organisations. Consider, where applicable, third sector partners involved in supporting recovery objectives for service users.

- Provide training on IPS to all clinical and management staff, with a focus on recovery stories to senior management and all CMHT staff.

- Make the referral process as simple as possible so paperwork doesn't become a barrier – e.g., consider accepting verbal referrals with the IPS service following up for all relevant information. Risk and safety issues are always discussed at the point of referral and documented on the clinical system. If there are complex risk and safety issues, then how this impacts on the return to work needs to be fully explored with the service user and clinical team and documented on the clinical system.

- Seek assistance and partnership in clinical risk management through supervision specific to this area with senior clinical staff.

- It cannot be underestimated how important team relationships are for confident and consistent referrals.

- Seek referrals from those most interested in the program first, the early adopters. Some case managers may be opposed to the program due to a lack of understanding about the value of the service.

- Ensure that ES's feed back on good news, i.e. job outcomes, at clinical and other business meetings. They should also report on any challenges or learning that the clinical team need to consider.

- Share Employment Recovery stories with the clinical team and service users, this could include written, in person and filmed stories.

- Consider enabling all service users of the team the ability to self-refer by approaching the employment specialist directly or by asking their case manager or health professional. To encourage this, put brochures in the waiting room, and telling family and careers about the program so that they can encourage self-referral.

- Articulate that expected referral rates could exceed 50% of all health service user numbers. Evidence (specifically in the UK 70-90%, Australia 85%, USA 90%), highlight that a high proportion of service users are "interested in employment" and hence candidates for a referral. If referrals are lower than this, then something else may be blocking them from accessing the service.

- Establish regular marketing and education initiatives about the programme aimed at clinicians and case managers, and other stake holders. This should be part of the implementation plan – agree how this looks with senior management commitment

- An ES should never cover more than two teams, as this spreads the service too thin to be effective in influencing clinicians and meeting demand.

- Do not use a waiting list beyond 5, and only put individuals on the list if they can be seen within 6 weeks, as it is important that people have support when they are motivated to return to work. Instead support the team to refer to external agencies, establish sign-posting services and information packs about local employment agencies. It is important to consider the whole population attached to a clinical team, not just those on the ES caseload.

- Monitor who is making referrals by recording the source in the database. Ask the Clinical Supervisor to explore referrals with their staff supervision. After several months you may want to seek one-one meetings with those who have not made referrals and request feedback as to their lack of engagement with the service. You could offer to go through their caseloads with them and discuss reasons why individuals were not referred. You could also check the caseload files to see which clients have a vocational goal and a treatment and recovery plan. Not referring to the employment program could be a sign of poor quality mental health care, or it could mean the case manager is providing the employment support already, or has another employment pathway in mind.

- Train clinical teams in how IPS works and the potential for a medium to long term reduction in demand for mental health services, if people stay well and stay in employment. There could be a short term increase in workload as the clinical team learn about how to work in parallel with an employment program, since this is an additional duty until they learn how the program works, then they will start to gain the benefits.

- Make it clear that clinicians' skills are critical in assisting with vocational planning and clinicians advice and liaison is crucial for supported employment.

- Look for ways to understand clinicians' concerns about a service user seeking and managing work and make plans to mitigate any concerns or risks (such as fear about loss of welfare benefits, fear that work will make the persons condition worse etc.).

- Measure the clinical team's attitudes to employment as part of recovery, using the HPPE scale before and after IPS implementation. Also analyze referral patterns to understand both who makes and does not make referrals within the team, and to ensure that the referral process is clear, efficient and timely. Consider setting targets for this as well.

- It is suggested that you have a clearly defined process to measure:

1. The date of a complete referral;
2. The date the decision to accept or reject the referral was made;
3. The reason for any referral being declined;
4. The date the person commenced to receive employment assistance;
5. Keep track of multiple referrals and incomplete referrals, and make sure these are entered into the data base every day or every second day.

- The service runs to IPS fidelity and must be at a rating of 4/5 on each measure by year two, with a clear focus on also meeting increasing employment outcome targets years on year and taking action to achieve this or remedy any variance.