BRIEFING

41: Commissioning what works

The economic and financial case for supported employment

Summary

This briefing is aimed mainly at those responsible for commissioning employment-related and other services for people with severe mental health problems. It analyses the economic and financial case for Individual Placement and Support (IPS), a form of supported employment which helps service users into paid competitive work.

There is abundant evidence to show that IPS is more effective than any other form of vocational support in helping people to get jobs. The additional evidence reviewed in this paper indicates that it is also good value for money and that it is affordable.

IPS costs no more than traditional vocational services such as sheltered work. Indeed it may be considerably cheaper when assessed over a period of years. It helps more people to find jobs, raises their incomes and improves their quality of life. And there is now increasing evidence to suggest that it can lead to long-term expenditure savings as those who find work make reduced use of mental health services.

The cost of implementing IPS at the level of provision recommended in government commissioning guidance on vocational services is estimated at around £67 million a year nationally (or £440,000 per average PCT). In comparison, current spending on day and employment services is around £184 million a year. This implies that IPS could readily be established within existing provision by diverting resources from less effective services.

Introduction

This briefing is part of a series being produced by Sainsbury Centre for Mental Health for an initiative to promote the systematic implementation of Individual Placement and Support (IPS), a form of employment support which helps people with severe and enduring mental health problems into competitive jobs.

Two papers in this series have already been published: *Doing What Works*, which sets out the main principles of IPS and related evidence on its effectiveness (Sainsbury Centre for Mental Health, 2009a); and *Measuring What Matters*, which provides a set of key performance indicators for monitoring the performance of employment support offered by specialist mental health services (Sainsbury Centre for Mental Health, 2009b). This briefing sets out the economic and financial case for IPS and is aimed primarily at commissioners.

IPS is designed to help people with severe mental health problems who are not currently in work. In line with this focus, the analysis set out in this paper does not deal with the support needs of people whose mental health problems are mild to moderate or with the important but separate issue of helping those who are already in work to retain their jobs (see Sainsbury Centre, 2009c).

What is IPS?

The great majority of people in contact with mental health services want to work, but only a small minority actually do. Up to 90% of mental health service users want to work (Secker *et al.*, 2001). Yet annual surveys of service users carried out by the Healthcare Commission (now the Care Quality Commission) show that the number in employment is only about 20%, a figure which has remained broadly constant for several years (Healthcare Commission, 2008).

One important reason for this low rate of employment is that the vocational training and rehabilitation services predominantly available to people with severe mental health problems are ineffective in helping their clients into competitive jobs. These services assume that people need a lengthy period of training and preparation (for example, in sheltered workshops) before seeking open employment. In practice, few manage to make the transition with any success.

IPS turns the logic of this traditional model on its head and says that the top priority is to get people into competitive employment as quickly as possible, with training and other support being provided on a continuing basis *after* job placement, not before. In short, place then train, rather than train then place.

The key principles of IPS are summarised in Box 1.

Box 1: The key principles of IPS

- Competitive employment is the primary goal;
- Everyone who wants it is eligible for employment support;
- Job search is consistent with individual preferences;
- Job search is rapid: beginning within one month;
- Employment specialists and clinical teams work and are located together;
- Support is time-unlimited and is individualised to both the employer and the employee;
- Welfare benefits counselling supports the person through the transition from benefits to work.

(Adapted from Bond *et al.*, 2008)

Research evidence demonstrates that adherence to each of these principles increases the effectiveness of IPS in helping people into work (Bond, 2004) and a detailed 'fidelity scale' is available to check the extent of compliance achieved by any individual employment service (Becker *et al.*, 2008).

Commissioners' questions

In deciding whether or not to commission a form of service provision such as IPS, commissioners will consider a number of questions:

- **Is the service effective?** Does it yield better outcomes than alternative methods of support?

- **Is it good value for money?** Do the benefits of the service exceed its costs, again in comparison with relevant alternatives?
- **Is it affordable?** What are the budgetary implications, both this year and over the longer term?

Abundant evidence is now available to demonstrate beyond reasonable doubt that IPS passes the effectiveness test. In helping people with severe mental health problems into work, it does much better than any known alternative. The existing evidence base on value for money and affordability is less comprehensive and less conclusive, but nevertheless sufficient to support a positive verdict. The following sections elaborate on these broad generalisations.

Is IPS effective?

Early work on the development of supported employment for people with severe mental illness, including IPS as a carefully specified variant, was largely undertaken in the US and systematic evidence on its effectiveness was first made known to a British audience in a Cochrane Review published in 2001 (Marshall *et al.*, 2001).

This summarised the findings of 18 randomised controlled trials from the US and concluded that supported employment was much more effective than traditional services offering pre-vocational training. On average across the 18 trials, 34% of people in supported employment were in work at 18 months after enrolment against 12% in pre-vocational training. Those in supported employment also earned more and worked more hours per month. Pre-vocational training was no more successful than standard community care in helping clients find competitive jobs.

Subsequent evidence has confirmed and strengthened these conclusions. For example, a review published in 2008 brought together findings from 11 randomised controlled trials which compared compliant IPS programmes with traditional vocational services and found that on average the employment rate was 61% for IPS compared with 23% for traditional services (Bond *et al.*, 2008). The effectiveness of IPS, both in absolute terms and relative to traditional services, was therefore considerably better than found in the 2001 Cochrane review of supported employment, attributable to the benefits of close adherence to the key principles of IPS and continuing refinements in its design and operation.

The 2008 review also found that on average about two-thirds of those who obtained competitive employment worked 20 hours or more per week, although very few worked full-time, and that among those who obtained a competitive job, IPS participants found their first job nearly 10 weeks earlier than those in traditional services.

Recent evidence also answers questions about whether IPS can successfully be implemented in the UK as well as in North America and about its long-term outcomes for people's employment and their health.

Transferability to the UK

Because the early development of IPS took place mainly in the US, questions were raised about the extent to which its success could be replicated elsewhere, given the many structural differences in the economy, the labour market and health and welfare systems between the US and other countries.

These concerns have largely been laid to rest, as there is now an increasingly strong body of evidence to show that IPS is readily transferable between countries, with broadly equivalent outcomes. For example, the 2008 review included findings from IPS trials in Canada and Australia and from a multi-site trial in six European centres including London. In all these cases employment outcomes were in line with those observed in US studies, with the European trial showing employment rates of 55% for IPS against 28% for traditional services.

Several IPS services now exist in the UK and where published results are available these confirm that IPS is significantly more effective than traditional services in enabling people with severe mental health problems to gain and retain open employment (Rinaldi and Perkins, 2007).

Sustainability of employment

Most published studies of IPS report employment outcomes at a follow-up point which is typically 12-24 months after clients

have first joined the programme. Because of the cost and complexity of following up people for much longer periods of time, particularly those who are no longer in receipt of services, less is known about outcomes over the long term.

Encouragingly, the small number of studies which do provide such information report positive findings. For example, one study which followed up a sample of IPS participants 8-12 years after enrolment found that all did some work during the follow-up period, the great majority (82%) in competitive jobs, and 71% worked for more than half of all months in the follow-up period (Becker *et al.*, 2007). As found in other studies, most jobs were part-time, 79% being for 20 hours a week or less.

Health impact of returning to work

Notwithstanding a large body of evidence which shows that employment is good for mental health and, even more strongly, that unemployment is bad for mental health (Waddell and Burton, 2006), concerns are often expressed that a return to work might be damaging for people who have severe mental illness. This proposition finds no support in the research literature relating to IPS. Indeed, a number of studies show that going back to work can lead to improvements in clinical and social functioning (Burns *et al.*, 2008) and none report any negative results.

There is also evidence, particularly from long-term studies, that increased employment has enduring benefits in terms of better self-reported quality of life, self-esteem and relationships with other people (Becker *et al.*, 2007).

Is IPS good value for money?

There can be little doubt that IPS is more effective than any other form of vocational support in helping people with severe mental health problems into work. But is it also more cost-effective? More generally, is the provision of IPS a good use of scarce resources from the point of view of society as a whole?

Few if any studies of IPS provide a comprehensive analysis of costs and benefits. For example, many give no information at all on costs and in others the coverage is often patchy and incomplete. Another important shortcoming in most studies is the limited period of time over which costs and benefits are measured. If, as seems plausible, IPS makes people *permanently* more employable, its potential benefits may extend over many years. They may indeed extend throughout working life, given that the first onset of schizophrenia and some other forms of severe mental illness is most common at ages 16-25. The full benefits of IPS may therefore be systematically understated in the published literature.

Notwithstanding these limitations, sufficient evidence is available to support a reasonably robust analysis of the key elements of an economic appraisal. The main building blocks are as follows.

Comparing IPS with traditional services

IPS has been described as *"relatively inexpensive and highly cost-effective relative to other forms of vocational services"* (Drake and Bond, 2008). This conclusion seems well supported, as the evidence shows that the much better outcomes associated with IPS can usually be achieved without any increase in the overall costs of vocational support and indeed probably some reduction.

The earliest evidence on costs was provided by a number of demonstration projects in the US which showed that traditional vocational services could be converted to IPS on a broadly cost-neutral basis (Clark *et al.*, 1996). The 2001 Cochrane review also found that there were *"no major differences"* in costs between supported employment and pre-vocational training (Marshall *et al.*, 2001) and subsequent randomised controlled trials comparing IPS with other forms of vocational support have generally come to a similar conclusion.

One possible qualification is that the costs of IPS can vary quite substantially from site to site, depending mainly on differences in the size of caseloads carried by the employment specialists who support clinical teams in delivering IPS services and also in the rate of client turnover (Latimer *et al.*, 2004). Such variations can however be substantially reduced by close adherence to the IPS fidelity scale, which includes clear guidance on the size of caseloads indicated by best practice.

A more important observation is that the costs of IPS relative to traditional services may be overstated because of the limited period of time over which they are usually measured. Most studies report annualised costs per client assessed over one or two years. For traditional services like sheltered workshops, this is adequate, as few participants move into open employment and for any individual client annual costs are likely to be much the same, whether averaged over one or two years or over a longer period. In the case of IPS, by contrast, many more clients move into open employment and – for some at least – their need for continuing support will decline or cease altogether. Average annual costs per client will therefore fall steadily over time.

The shortage of long-term follow-up information on IPS makes it difficult to quantify this effect with precision, but even without any adjustment for declining unit costs it is clear that IPS scores well on cost-effectiveness grounds against other forms of vocational support. At worst costs are the same, but outcomes as measured by the numbers supported into open employment are two to three times better. The direct costs of providing an IPS service are discussed in the section on affordability.

Impact on mental health service costs

In addition to the direct costs of IPS, covering expenditure on employment specialists and related support, also relevant to any economic or financial appraisal is the potential impact of IPS on mental health service costs, including hospital provision and community-based services. Do the better outcomes associated with IPS lead to lower spending on mental health care?

The published literature on IPS has generally taken a cautious line on the scope for such savings, but emerging new evidence is increasingly suggesting that savings can be made, possibly on a substantial scale. Again a good deal seems to depend on the time period over which the costs and benefits of IPS are measured.

Short-term savings

Dealing first with the majority of studies which focus on short-term effects, the balance of evidence from the US is that while there is no evidence of health care costs increasing with IPS, any reductions that do occur are usually insignificant in scale (Latimer, 2001). Two recent non-US studies suggest that this conclusion may need to be modified.

First, a multi-site European trial found that rates of hospital use were lower for IPS clients than for those in traditional services (Burns and Catty, 2008). In particular, only 20% of IPS participants were re-hospitalised at any time during the 18-month follow-up period compared with 31% of those in traditional services, while the proportion of time spent in hospital over the 18 months was only 4.6% for IPS clients against 8.9% for those in traditional services.

It should be noted that the interpretation of this change is open to question, as the relatively lower rate of hospital use among IPS participants occurred very largely in the first six months of the follow-up period and was not maintained. Subject to this qualification, the figures imply a saving of around £6,000 per client in inpatient costs over the 18-month period, based on the average cost of psychiatric inpatient care in England (Department of Health, 2009). This was twice the total direct cost of IPS services over the same period in this trial, which was less than £3,000 per client.

Second, a recent non-randomised study of supported employment including IPS in England has collected information on the use of mental health services over a 12-month period (Schneider *et al.*, forthcoming). This shows a significant reduction in service use among people who entered employment during the follow-up period. Comparing this group with those members of the sample who remained unemployed throughout the year, weekly spending on mental health services was very similar for both groups at baseline. For those who remained unemployed, spending per head was much the same 12 months later, but among those who found work it fell by over 60%. Interpreting this change as an effect rather than a cause of finding work, the study concludes that *"mental health service providers may save money if their service users get jobs"*.

Long-term savings

Two US studies based on 10-year follow-ups have produced evidence that *"stable employment may sharply reduce the overall costs of mental health care"* (Perkins *et al.*, 2005).

The more recent of these two studies provides information on employment and service use in a sample of 187 service users with severe mental illness and co-occurring substance use problems (Bush *et al.*, 2009). Analysed retrospectively, the sample divides into two groups: a 'steady work' group, whose work hours increased rapidly and then stabilised to average about 5,800 hours per person over 10 years, and a 'minimum work' group, whose work engagement was much lower at about 500 hours per person over 10 years. The 'steady work' group made up 28% of the sample and among this group spending on mental health inpatient and outpatient services was lower than among the 'minimum work' group by no less than $166,350 per head over 10 years.

Statistical analysis shows that this dramatic difference cannot be explained by differences in the severity of illness between the two groups and is instead more plausibly interpreted as a consequence of people finding and keeping work. This long-term study suggests that stable employment promotes recovery for people with severe mental illness, leading to a better quality of life *and* much reduced use of mental health services.

Drake (2008) has suggested as a broad generalisation that of all people going through IPS programmes about a third become consistent workers, a third become occasional or inconsistent workers and a third do not become competitively employed at all. The scope for savings in mental health service costs resides very largely in the first of these groups but may be substantial, with one study suggesting that service costs for consistent workers over a 10-year period may be lower by 50% than among other groups (Bush *et al.*, 2009).

In England, the public sector cost of providing health and social care for someone with a diagnosis of schizophrenia is around £10,000 a year (based on figures in McCrone *et al.*, 2008). Reducing these costs by 50% over 10 years would therefore represent a saving of some £50,000 – far more than the costs of providing IPS to the individual, which at most would come to about £20,000 over the same period and probably much less among those becoming consistent workers.

Increased earnings

IPS clients are considerably more likely to be in competitive employment than people supported by traditional vocational services. Largely as a corollary of this, they also work more hours over the course of a year and have higher annual earnings.

From the perspective of society as a whole, all of this increase in earnings counts as a benefit in an economic appraisal. Most of the benefit is likely to accrue to the individual in the form of higher income, but some may also accrue to the taxpayer in the form of reduced spending on social security benefits and/or increased revenue from taxation. How the benefit is distributed between different groups in society has no bearing on its total size or economic value.

Research evidence suggests that the overall scale of increased earnings is relatively modest, notwithstanding the higher rate of employment associated with IPS. There are various reasons for this.

Job tenures are typically fairly short. This is because individuals with severe mental illness often have to give up work temporarily for health or other reasons. Many people move in and out of employment rather than being continuously in work throughout the year.

Average hourly earnings are generally low. A recent study of supported employment including IPS in this country found that among clients in work average hourly pay was only about 25% higher than the national minimum wage (Schneider *et al.*, forthcoming). US evidence suggests a similar margin (Perkins *et al.*, 2005).

Nearly all jobs taken by people with severe mental illness are part-time. This may reflect personal preferences but it is also likely to be influenced by the rules of entitlement for social security and other benefits. For example, in this country people on Incapacity Benefit (now Employment and Support Allowance for new claimants) can work without loss of benefit only if they are employed for less than 16 hours a week, with earnings up to £92 a week. The so-called benefits trap is even more pronounced in the US, as working more than a permitted number of hours may lead to the loss of state-funded health insurance as well as welfare benefits.

An illustrative estimate of the scale of increased earnings can be based on data collected in the multi-site European trial of IPS (Burns and Catty, 2008). This shows that IPS clients worked for an average of 429 hours over the course of an 18-month follow-up period, while those receiving traditional vocational services worked for an average of 119 hours. The net benefit of IPS thus amounts to an extra 310 hours of work over 18 months, or 207 hours a year. Expressing this in monetary terms, the UK minimum wage is currently set at £5.73 an hour, so increasing this by the 25% mark-up suggested by Schneider *et al.* (forthcoming) leads to an overall estimate of net additional earnings associated with IPS of nearly £1,500 a year per client. Again this looks to be broadly consistent with comparable figures suggested by the US evidence.

Value for money: the verdict

It is clear that IPS is much more cost-effective than other forms of vocational support. Costs are the same or lower and outcomes are much better. A more demanding test is whether IPS is good value for money in an absolute rather than relative sense, i.e. do the benefits of this service outweigh its costs? Taking into account new findings on the scope for savings in mental health service costs as well as the monetary benefits of increased employment, the evidence again points to a positive verdict. The case is even stronger when allowance is made for benefits which cannot easily be measured in monetary terms, such as improved quality of life and reduced social exclusion. It is also likely that the balance of costs and benefits becomes increasingly favourable the longer the period of time over which it is measured.

Is IPS affordable?

The findings summarised here indicate that IPS has a strong evidence base on both effectiveness and cost-effectiveness grounds. NHS and other commissioners also need to take into account the possible budgetary implications, particularly when – looking ahead – the resources available for health and social care are likely to be more constrained than in the recent past.

The overall financial impact of IPS depends on: the direct costs of employment support; the extent to which IPS can be financed by reducing the provision of other, less effective vocational services; and the possible scale of offsetting savings in mental health service costs.

Direct costs of IPS

A range of evidence suggests that in today's prices the annual direct cost of IPS works out at around £2,000 per place (or, equivalently, the cost of supporting one client on an IPS programme for a year). This figure is broadly consistent with the US evidence on costs which, according to one recent review, suggests a figure of about £1,925 per place (Latimer, 2008). It is also consistent with the evidence for this country. For example, cost per place for the London site in the multi-site European trial was £2,375 over 18 months, measured in 2003 prices. Taking into account NHS pay and price inflation since 2003, this is equivalent to around £1,870 over 12 months.

IPS services are provided by employment specialists (with appropriate management and administrative support) working closely with community-based mental health teams. Another way of looking at costs is therefore to provide data on the cost of employment specialists and to combine this with information on caseloads in order to produce an estimate of cost per place.

Box 2 gives a case study of IPS services provided in Surrey by the voluntary sector agency, Richmond Fellowship, and includes some financial information (see page 9). The full cost of an IPS programme based on six employment specialists is shown as £280,000 a year, including the cost of management and administrative support and other overheads as well as the pay of the employment specialists. Allocating all of these costs to the employment specialists, the unit cost is £46,667 a year per specialist.

Concerning caseloads, the current version of the US fidelity scale for IPS gives suggested ratings of 1 (low fidelity) to 5 (high fidelity) for a range of programme features and indicates ratings of 4 for caseloads of 21-25 per employment specialist and 5 for caseloads of 20 or fewer (Becker *et al.*, 2008). In this country, official commissioning guidance on vocational services for people with severe mental health problems recommends caseloads per employment specialist of *"up to 25 people at any one time"*

(Department of Health & Department for Work and Pensions, 2006).

In broad terms, the cost of an employment specialist (including overheads and support) is thus in the range £45-50,000 a year and recommended caseloads are in the range 20-25. These figures confirm that an estimate of £2,000 a year per IPS place is broadly appropriate for financial planning purposes.

The overall level of provision recommended in the DH/DWP commissioning guidance on vocational services is for one whole-time equivalent employment specialist per clinical mental health team. In 2008 there were altogether 1,428 clinical teams in England, including 760 generic community mental health teams and 668 specialist teams providing assertive outreach, crisis resolution and early intervention services (Mental Health Strategies, 2009).

Applying the unit cost of £46,667 a year for an employment specialist, the direct cost of providing IPS services at the recommended level throughout the country is estimated at £66.6 million a year. This is equivalent to expenditure of just under £440,000 a year per average PCT. The national total represents 1.2% of aggregate spending on mental health services for adults of working age.

Replacement of existing services

The figure of £66.6 million a year is a gross cost and thus assumes that all IPS services would be in addition to existing vocational provision. In practice IPS is more realistically seen as a superior alternative to other services and, as seen in the section on value for money, the evidence suggests that where IPS takes the place of an existing vocational service, the change can generally be achieved on a cost-neutral or cost-saving basis over a period of years.

National spending (including overheads etc.) on day and employment services amounted to around £184 million in 2007/08 (Mental Health Strategies, 2008). Within this total, nearly £34 million is specifically identified as expenditure on employment schemes. Spending of £66.6 million a year to meet the recommended national level of provision for IPS is therefore equivalent to roughly twice the current level of expenditure on employment schemes but only about a third of total expenditure on day and employment services.

The current balance of spending seems to reflect under-investment in evidence-based employment schemes and over-investment in traditional day services. Expanding the provision of IPS to the level recommended in national guidance could readily be achieved within existing provision by transferring funds from traditional services. Detailed guidance on how to recommission day and employment services is given in the Sainsbury Centre publication *About Time* (Lockett *et al.*, 2008).

Affordability: the verdict

It is clear that IPS is a relatively low cost intervention, even leaving to one side possible long-term savings in mental health service costs, which are rather speculative. Where it replaces existing vocational provision, the budgetary impact is more likely to be favourable than the reverse, and even in the less favourable scenario where all IPS services entail extra spending, the cost burden is relatively minor, with provision according to national norms costing at most about 1% of mental health service budgets.

Concluding remarks

The main objective of this paper has been to assess the economic and financial case for IPS, but it may be helpful to conclude by noting that the effective procurement of this service also contributes in various ways to wider commissioning objectives.

Health policy and guidance

The commissioning of IPS is strongly recommended in official guidance on vocational services for people with severe mental health problems (Department of Health & Department for Work and Pensions, 2006) and in the Government's action plan on social exclusion (Cabinet Office, 2006). It supports the delivery of Standard 1 of the National Service Framework for mental health (on promoting social inclusion) (Department of Health, 1999) and, more generally, contributes to the work of community-based mental health teams in improving

Box 2: Richmond Fellowship Mid Surrey

In 2006 Richmond Fellowship (RF) was commissioned by Surrey Health and Social Care to provide a range of specialist mental health employment services in East Surrey and to co-ordinate partnership working with other organisations to achieve employment and social inclusion outcomes. RF Mid Surrey was set up to provide these services, reaching out from accessible central High Street offices to more remote rural districts to the south and to urban districts inside the M25.

RF Mid Surrey's main provision is an evidence-based Employment Advice Service, delivered by full-time employment advisors, for people who express a preference for gaining paid employment. This service is complemented by a 'Retain' specialist job retention service, IT training for people requiring skills updates and a Community Links Advice service for people whose recovery goals are unpaid work and involvement in mainstream activities. As an independent voluntary sector organisation, RF has developed its own model of employment support.

RF Mid Surrey's Employment Advice Service adheres to IPS principles:

- Employment advisors assist clients to develop action plans which always focus on competitive employment as the end goal.
- Eligibility is based purely on individual choice rather than diagnosis.
- Referrals are acknowledged within 48 hours and job search can be undertaken at first meeting.
- Employment advisors have caseload and contact responsibilities for one secondary mental health team each and shared geographic responsibility for a locality-wide service. Advisors have caseloads of 25 to 30 referrals and meet monthly with a clinical vocational lead occupational therapist for their NHS team to discuss referrals, with additional *ad hoc* contact as required.
- Advisors discuss an individual's strengths, job preferences and personal requirements to optimise the sustainability of eventual employment.
- These discussions form the basis for personalised support to increase a client's self esteem, confidence and empowerment to self-determination and self-efficacy.
- Advisors discuss benefit concerns and assist clients to access specialist 'better-off' calculations before securing employment.

Employment outcomes

Over the three financial years 2006/07 to 2008/09, 100 out of 187 clients supported by the Mid-Surrey Employment Advice Service achieved paid employment outcomes, equivalent to 53.5% of the total. A further 78 clients were supported into unpaid employment, training and education. Among those finding employment, 67% worked for 16 or more hours a week.

Costs

Although the benefits attributable to the Employment Advice Service are clear, specific costs associated with the service are difficult to isolate from the whole RF Mid Surrey budget. However, in 2009 Richmond Fellowship were commissioned to deliver an evidence-based (IPS) Employment Advice Service across West Surrey. Based on the outcomes achieved by RF Mid Surrey it is projected that the West Surrey service will generate the following outcomes:

- Support for 330 people per year, 165 of whom will be new referrals;
- 90 people to receive support to gain and retain paid employment;
- A further 60 to achieve unpaid work, training, or education goals.

The total cost of the service required to deliver these outcomes is £280,000 a year including staff costs for six employment advisors, 0.75 FTE management (with no caseload responsibilities), and 0.4 administrators. Central management, training and the resources of Richmond Fellowship's national organisation are all included in this budget.

outcomes for people with severe and enduring mental illness.

IPS is strongly consistent with the current national focus on recovery-oriented mental health services (Shepherd *et al.* 2008) and enabling people to find work addresses something which service users themselves frequently highlight as a priority.

IPS promotes joint working between the NHS, local authorities and the Department for Work and Pensions. It is also an important area for commissioning from the third sector.

Wider policy goals

Implementation of IPS supports the delivery of the Government's national policy objective, specified in Public Service Agreement (PSA) 16, to *"increase the proportion of socially excluded adults in settled accommodation, employment, education or training"*. The National Indicator Set, which forms part of the PSA framework, specifically includes an indicator (NI150) that measures the proportion of *"adults in contact with secondary mental health services in employment"*.

Implementation of IPS also supports the Government's objectives for welfare reform, which include reducing the number of people claiming Incapacity Benefit and Employment and Support Allowance.

Support for commissioners

The steadily increasing use of IPS in this country means that there is now a body of knowledge and expertise which commissioners can exploit, including talking to fellow commissioners. And there is a developing market of potential service providers.

The commissioning of IPS can be supported by a more detailed, explicit and outcome-focused service specification than other forms of vocational provision and can be monitored against readily measurable outcome data. For a sample service specification, see Sainsbury Centre (2009d), and for outcome measures, see Sainsbury Centre (2009b).

Invest now, save later

With the economy in recession and unemployment rising, it is sometimes suggested that now is not an appropriate time to expand employment support for a group who may be particularly likely to struggle in a weakening labour market. This, however, is a short-sighted view.

The recession will not last forever and IPS should be seen as a long-term programme, aimed at helping people to move forward in small steps, keeping them in touch with the labour market and positioning them favourably to take advantage of job opportunities as and when economic conditions improve. People with severe and enduring mental health problems have long-term needs and require long-term commitment from services.

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References

Becker, D.R., Swanson, S.J., Bond, G.R., Carlson, L., Flint, L., Smith, G. & Lynde, D. (2008) *Supported Employment Fidelity Scale.* Lebanon, NH: Dartmouth Psychiatric Research Center.

Becker, D., Whitley, R., Bailey, E. & Drake, R. (2007) Long-term employment trajectories among participants with severe mental illness in supported employment. *Psychiatric Services,* **58** (7) 922-928.

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

Bond, G., Drake, R. & Becker, D. (2008) An update on randomized controlled trials of evidence-based supported employment. *Psychiatric Rehabilitation Journal*, **31**, 280-290.

Burns, T. & Catty, J. (2008) IPS in Europe: the EQOLISE trial. *Psychiatric Rehabilitation Journal*, **31**, 313-317.

Burns, T., Catty, J., White, S. *et al.* (2008) The impact of supported employment and working on clinical and social functioning: results of an international study of Individual Placement and Support. *Schizophrenia Bulletin*, Advance Access, 21 April 2008.

Bush, P., Drake, R., Xie, H., McHugo, G. & Haslett, W. (2009) The long-term impact of employment on mental health service use and costs. *Psychiatric Services* (in press).

Cabinet Office Social Exclusion Task Force (2006) *Reaching Out: An action plan on social exclusion.* London: Cabinet Office.

Clark, R., Bush, P., Becker, D. *et al.* (1996) A cost-effectiveness comparison of supported employment and rehabilitative day treatment. *Administration and Policy in Mental Health*, **24**, 63-77.

Department of Health (1999) *National Service Framework for Mental Health: Modern standards and service models.* London: Department of Health.

Department of Health (2009) *NHS Reference Costs 2007/08.* London: Department of Health.

Department of Health & Department for Work and Pensions (2006) *Vocational services for People with Severe Mental Health Problems: Commissioning guidance.* London: Department of Health.

Drake, R. (2008) *The Future of Supported Employment.* Sainsbury Centre Lecture, March 2008. http://www.scmh.org.uk/employment/ips_resources.aspx

Drake, R. & Bond, G. (2008) The future of supported employment for people with severe mental illness. *Psychiatric Rehabilitation Journal*, **31** (4) 367-376.

Healthcare Commission (2008) *The 2008 Survey of Community Mental Health Services.* London: Healthcare Commission. http://www.cqc.org.uk/publications.cfm

Latimer, E. (2001) Economic impacts of supported employment for people with severe mental illness. *Canadian Journal of Psychiatry*, **46**, 496-505.

Latimer, E. (2008) *On the economics of evidence-based supported employment for people with severe mental illness.* Lecture at the London School of Economics, 5 February 2008, unpublished.

Latimer, E., Bush, P., Becker, D., Drake, R. & Bond, G. (2004) The cost of high-fidelity supported employment programs for people with severe mental illness. *Psychiatric Services*, **55** (4) 401-406.

Lockett, H., Seymour, L. & Pozner, A. (2008) *About Time: Commissioning to transform day and vocational services.* London: Sainsbury Centre for Mental Health.

Marshall, M., Bond, G. & Huxley, P. (2001) Vocational rehabilitation for people with severe mental illness. *Cochrane Database of Systematic Reviews 2001,* Issue 2.

McCrone, P., Dhanasiri, S, Patel, A., Knapp, M. & Lawton-Smith, S. (2008) *Paying the Price: The cost of mental health care in England, projections to 2026.* London: King's Fund.

Mental Health Strategies (2008) *The 2007/08 national survey of investment in mental health services.* http://www.dh.gov.uk/en/Publicationsandstatistics

Mental Health Strategies (2009) *Combined Mapping Framework: Reports.* http://www.mhcombinedmap.org

Perkins, D., Born, D., Raines, J. & Galka, S. (2005) Program evaluation from an ecological perspective: supported employment services for people with serious psychiatric disabilities. *Psychiatric Rehabilitation Journal*, **28** (3) 217-224.

Rinaldi, M. & Perkins, R. (2007) Comparing employment outcomes for two vocational services: Individual Placement and Support and non-integrated pre-vocational services in the UK. *Journal of Vocational Rehabilitation*, **27**, 21-27.

Sainsbury Centre (2009a) *Briefing 37: Doing What Works, Individual Placement and Support into employment.* London: Sainsbury Centre for Mental Health.

Sainsbury Centre (2009b) *Measuring What Matters: Key indicators for the development of evidence-based employment services.* London: Sainsbury Centre for Mental Health.

Sainsbury Centre (2009c) *Delivering Job Retention Services: A knowledge and skills set for employment advisory services located in primary care settings.* http://www.scmh.org.uk/publications/delivering_job_retention_services.aspx?ID=599

Sainsbury Centre (2009d) *Sample service specification for vocational service.* http://www.scmh.org.uk/pdfs/About_Time_additional_resource3_service_spec_vocational_service.pdf

Schneider, J. *et al.* (forthcoming) Impact of supported employment on service costs and income of people with mental health needs. *Journal of Mental Health* (accepted for publication).

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.

Shepherd, G., Boardman, J. & Slade, M. (2008) *Making Recovery a Reality.* London: Sainsbury Centre for Mental Health.

Waddell, G. & Burton, A. (2006) *Is Work Good for your Health and Well-being?* London: TSO.

Briefing 41: Commissioning what works

The economic and financial case for supported employment

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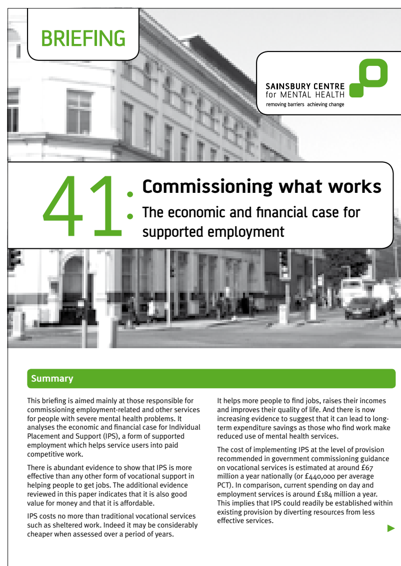
BRIEFING

SAINSBURY CENTRE for MENTAL HEALTH

removing barriers achieving change

41: Commissioning what works

The economic and financial case for supported employment

Summary

This briefing is aimed mainly at those responsible for commissioning employment-related and other services for people with severe mental health problems. It analyses the economic and financial case for Individual Placement and Support (IPS), a form of supported employment which helps service users into paid competitive work.

There is abundant evidence to show that IPS is more effective than any other form of vocational support in helping people to get jobs. The additional evidence reviewed in this paper indicates that it is also good value for money and that it is affordable.

IPS costs no more than traditional vocational services such as sheltered work. Indeed it may be considerably cheaper when assessed over a period of years.

It helps more people to find jobs, raises their incomes and improves their quality of life. And there is now increasing evidence to suggest that it can lead to long-term expenditure savings as those who find work make reduced use of mental health services.

The cost of implementing IPS at the level of provision recommended in government commissioning guidance on vocational services is estimated at around £67 million a year nationally (or £440,000 per average PCT). In comparison, current spending on day and employment services is around £184 million a year. This implies that IPS could readily be established within existing provision by diverting resources from less effective services.

SAINSBURY CENTRE
for MENTAL HEALTH
removing barriers achieving change

Sainsbury Centre for Mental Health
134–138 Borough High Street, London SE1 1LB

T 020 7827 8300

F 020 7827 8369

www.scmh.org.uk

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