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The economic case for well-considered investment in health-related employment support: Costs and savings of alternative modified Individual and Placement Support (IPS) models

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ABSTRACT

Background: Health-related unemployment is a major issue across advanced economies. Modified versions of well-evidenced Individual Placement and Support (IPS) models of employment support for health cohorts offer considerable potential. A significant gap currently however is the lack of evidence around their financial return on investment.
Objective/Hypothesis: To provide robust financial return on investment estimates for analytically derived alternative specifications of modified IPS services for the first time in the literature, sensitivity tested across various levels of performance.
Methods: Brings together modelled cost and savings estimates based on best available evidence to deliver modelled return on investment estimates.
Results: The modelled estimates show that well-designed modified IPS services can deliver financial savings whilst tackling health-related unemployment, even at higher average unit costs than are typically considered viable in some national contexts.
Conclusions: Modified IPS services offer a viable route to delivering enhanced employment outcomes for individuals with health conditions and disabilities and financial savings for governments.

1. Introduction

The intertwined work-health 'problems' of health-related unemployment, sickness absence and reduced productivity are significant and stubborn across the advanced economies.[1,2] Whilst good work is known to be good for health[3,4] disability employment gaps – and the significant financial and non-financial harms that result for individuals, businesses, Exchequers and society more widely – are increasingly unable and unwilling to be tolerated.

There is thus an urgent need to develop more effective upstream preventative employment programmes for unemployed individuals with health conditions and disabilities. Whilst many interventions have demonstrably failed, a body of solid evidence has developed around a model known as Individual Placement and Support (IPS).[5–10] This IPS model emphasises client preferences and a rapid place-then-train employment model towards well-matched competitive employment from day one, with individuals supported intensively by employment specialists with low caseloads integrated into secondary mental health teams and conducting proactive employer engagement. The effectiveness of IPS to deliver employment outcomes is substantial, even if the dominance of US trials leads some to question whether IPS can be said to be equally effective in all contexts. IPS services on average see job entry rates of 61% for IPS participants compared with 23% for randomly allocated control groups[11] – an impact of 38% points, far in excess of performance typically seen in employment programmes for a health and disability cohort.

Nevertheless, IPS is in its current configuration a niche employment support model that is unable to make significant inroads into the totality of the health-related employment challenge. Specifically, IPS is severely limited by narrowness across four key dimensions: *cohort* (a severe mental health cohort only); *setting* (secondary mental health services only); *function* (transitions from out-of-work into employment); and *scale* (low volumes supported).

Unsurprisingly, there is considerable interest and activity in flexing traditional IPS to retain its best elements whilst enabling it to cater to the differing needs of wider, larger cohorts in new settings and with new functions. Such stretched IPS models have not been trialled and shown to succeed, yet reflection of the key

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principles and characteristics that underpin the success of IPS – low caseloads, person-centred support, effective job matching, proactive employer engagement, integrated work and health support packages – are all in principle translatable to, and hence offer significant promise for, wider cohorts.

Central to the effectiveness of IPS is the twenty-five item 'fidelity scale' shown in Table 1 against which IPS services can be measured in terms of their fidelity and quality.[12] For traditional IPS services the fidelity scale is a powerful guide to designing and delivering high quality IPS services and performance. For modified IPS services the key challenge is to effectively flex the fidelity items as required for the differing needs of their larger and wider cohorts and primary care contexts whilst retaining the core ethos, quality and performance of the IPS model, albeit in a partially modified form.

Recent analytical work outlines a framework to guide the effective translation of IPS fidelity into modified IPS services.[13] That analytical framework is informed by the author's leading of a collaborative codesign process with central and local government policy colleagues to assess, and where required modify, the IPS fidelity items for the purposes of a large-scale UK government funded modified IPS trial providing voluntary employment support to individuals with low to moderate mental health and/or physical health conditions.

Such analytical thinking offers necessary but not sufficient foundations for the effective large-scale development modified IPS services given that the financial case for those investments must also be made. This present article progresses to that critical economic second step by presenting for the first time in the literature a robust assessment of cost and return on investment profiles of twelve alternative analytically derived modified IPS services, sensitivity tested across varying levels of performance.

Table 1 differentiates between what XXXX[13] describe as 'standard' fidelity items in its upper row. These are traditional IPS fidelity items that can be applied equally across both traditional and modified IPS services according to the same underlying measurement and scoring criteria. In contrast, Table 1 shows in its lower row a set of qualitatively different 'modifiable' fidelity items that are identified through codesign discussions as in need of rethinking in order to translate effectively to the differing low to moderate cohorts and primary care settings of a modified IPS service. These modifiable fidelity items seek to achieve the same ends or functions as in the traditional IPS fidelity scale but require qualitative reconfiguration of their nature and underlying scoring criteria – the means through which to achieve those ends –to achieve them, reconfiguration whose viability and optimality depends on the particular programme and context at hand.

In thinking about modified IPS models an analytical differentiation is proposed between 'networked' and 'discrete' approaches. Traditional IPS services operate discretely as self-contained entities within secondary mental health services. Similarly, discrete approaches to the reconfiguration of these modifiable fidelity items place responsibility for their delivery on the IPS employment specialists internal to the service. In contrast, in networked approaches IPS employment specialists are tasked with co-ordinating support from existing services, resources and expertise within the wider health and employment system rather than delivering these functions themselves.

Fig. 1 below summarises the resulting analytical framework visually, with a key idea being the potential for multiple qualitatively different (horizontal axis) but equally quantitatively 'faithful' (vertical axis) modified IPS models, unlike the unidimensional understanding of quality in traditional IPS.

Designers of modified IPS services need to think carefully about how best to reconfigure each of those seven identified modifiable fidelity items across this networked-discrete axis if they are to maximise performance in modified IPS services. For this paper's financial focus, however, only two of those items are key to the costs and savings of any modified IPS service: employment services staff roles and employment engagement frequency.

Firstly, there are decisions around how modified IPS services meet the whole-person support needs of individuals, particularly health and wider support needs (e.g. housing, debt, family issues). In terms of health needs, unlike traditional IPS models in secondary mental health settings none of the primary healthcare practitioners in modified IPS services offer a dedicated health anchor to service users and all tend to be under significant demand pressure and rationing. Against this backdrop, employment specialists in modified IPS services might usefully adopt a partially discrete approach to the delivery of lower-level health supports by expanding their employment-only role to become trained in the delivery of lower-level mental and physical health interventions for their caseloads.

Table 1
IPS fidelity scale items.

Standard fidelity items	• Caseloads are small • Employment specialists deliver all phases of the employment support journey • Employment specialists are integrated into appropriate healthcare practices • Employment specialists work together in supervised teams • Supervisors have max 10 employment specialists per team and drive service quality • Zero exclusion criteria apply to service users • Service users received specialists financial advice around benefits and work transitions • Service users receive specialist advice around disclosure of health conditions • Service user support is based on regularly reviewed whole- person assessment • Place-then-train model of rapid supported job search starting within first 30 days • Individualised job search based on effective job matching to client preferences • Employment specialists deliver personalised employer contact to understand needs and deliver effective job matching • Employment specialists identify a diverse range of job opportunities • Employment specialists identify opportunities in a diverse range of employers • Competitive open employment is the day one goal • Employment specialists deliver personalised in-work support where employment occurs • Employment specialists meet with service users in accessible community based settings
Modifiable fidelity items	• Employment services staff focus on delivery of employment support • Employment specialists are integrated into appropriate healthcare teams • Employment specialists collaborate with Public Employment Services (PES) • Employment specialists contact employers often and proactively to source vacancies • NHS Trust has focus on open employment as the goal for individuals with health issues • There is Executive level support within the NHS Trust for IPS

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