Process evaluation of the Individual Placement and Support for Alcohol and Drug dependence (IPS-AD) trial

Final report

Joanna Hofman, Natalie Picken, Jan Hutchinson, Androulla Harris, Katherine Stewart, Emma Disley
People with alcohol and drug dependence often struggle to find stable employment. Despite employment being identified as a key part of recovery by successive governments’ drug strategies, employment rates for people in both alcohol and drug treatment remain low compared to the general population.

Individual Placement and Support (IPS) could help to address this situation. IPS is an evidence-based approach already being used to support people with severe mental illness to gain employment. It brings trained IPS Employment Specialists (ESs) into clinical teams to provide intensive, individual support, and rapid job search followed by commencement of competitive employment, and in-work support for the employee and the employer. Public Health England (PHE) was commissioned by the joint Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC) Work and Health Unit to run a trial of IPS in alcohol and drug dependence community treatment services. In this new context, IPS supported people accessing drug and/or alcohol treatment who were looking for employment, using ESs alongside treatment for alcohol and drug dependence as part of a multi-disciplinary treatment team. Involving providers and local authorities in seven areas across England, the trial was the first large-scale randomised controlled trial (RCT) of IPS for this client group.

In the trial, the IPS approach was compared with the standard employment supports for unemployed and inactive people receiving community treatment for alcohol and drug dependence. RAND Europe and the Centre for Mental Health (CMH) were commissioned by PHE to conduct a process evaluation of the trial. This report provides overall findings from three rounds of data collection, involving 257 interviews with treatment services staff, the IPS teams and trial participants in all seven areas. It relates the experiences of those involved in the implementation of IPS in treatment services since the inception period, and the experience of participants in both the treatment and control groups.

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## Abbreviations and acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEH-MHT</td>
<td>Barnet Enfield and Haringey Mental Health Trust</td>
</tr>
<tr>
<td>CMH</td>
<td>Centre for Mental Health</td>
</tr>
<tr>
<td>DHSC</td>
<td>Department of Health and Social Care</td>
</tr>
<tr>
<td>DWP</td>
<td>Department for Work and Pensions</td>
</tr>
<tr>
<td>COM</td>
<td>Commissioner</td>
</tr>
<tr>
<td>DRP</td>
<td>Derbyshire Recovery Partnership</td>
</tr>
<tr>
<td>EMPL</td>
<td>Employer</td>
</tr>
<tr>
<td>EOI</td>
<td>Expression of Interest</td>
</tr>
<tr>
<td>ES</td>
<td>Employment Specialist</td>
</tr>
<tr>
<td>EQ</td>
<td>Evaluation question</td>
</tr>
<tr>
<td>IPS</td>
<td>Individual Placement and Support</td>
</tr>
<tr>
<td>IPS-AD</td>
<td>IPS trial for people receiving community treatment for alcohol and drug dependence</td>
</tr>
<tr>
<td>JCP</td>
<td>Jobcentre Plus</td>
</tr>
<tr>
<td>NDTMS</td>
<td>National Drug Treatment Monitoring System</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>PIs</td>
<td>Principal investigators (who also work as Senior Employment Specialists in the trial sites)</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised Controlled Trial</td>
</tr>
<tr>
<td>SES</td>
<td>Senior Employment Specialist</td>
</tr>
<tr>
<td>SHSC</td>
<td>Sheffield Health and Social Care NHS Foundation Trust</td>
</tr>
<tr>
<td>TAU</td>
<td>Treatment as Usual</td>
</tr>
<tr>
<td>TS</td>
<td>Treatment Service</td>
</tr>
<tr>
<td>TSK</td>
<td>Treatment Service Keyworker</td>
</tr>
<tr>
<td>TSM</td>
<td>Treatment Service Manager</td>
</tr>
<tr>
<td>ToC</td>
<td>Theory of Change</td>
</tr>
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</table>
Acknowledgements

This study was produced by an independent research team and its conclusions may not reflect the views of PHE.

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Chapter 1. Introduction

1.1. Background to the trial

Alcohol and drug dependence affects employment outcomes, yet the current employment support for people in treatment is limited. Alcohol and drug dependence can harm individuals, families, and society at large. Whether alcohol and drug dependence is a cause or a consequence of unemployment is not always clear, but it is undoubtedly a predictor of unemployment and future job loss. The employment rate for those in treatment for alcohol and drug dependence in England is considerably less than half that of the rest of the population. There is, however, a positive relationship between employment and recovery and some evidence suggests that having a job can moderate relapse.

An independent review into the impact on employment outcomes of drug or alcohol dependence and obesity carried out in England concluded that treatment provision should incorporate additional support, such as help to find employment. The review recommended a randomised controlled trial (RCT) to determine the effectiveness of the Individual Placement and Support (IPS) approach in drug and alcohol treatment settings.

IPS is a well-evidenced approach to support people into employment. Traditionally, IPS is used in secondary care settings for people who have severe mental illness. The IPS model follows the following eight principles:

- Competitive employment is the goal: competitive employment is defined as paying at least National Living or Minimum Wage and the wage that others receive performing the same work, based in community settings alongside others without disabilities, and not reserved for people with disabilities.
- IPS supported employment is integrated with treatment: Employment Specialists are members of multidisciplinary teams that meet regularly to review client progress.
- Zero exclusion – eligibility is based on client choice: every person who wants to work is eligible for IPS supported employment, regardless of diagnosis, symptoms, work history, or other problems.
- Attention to client preferences: client preferences help to determine the type of job that is sought, the nature of support provided by the ES and team, and the decision about whether to disclose the aspects of a person's disability to the employer.
- Benefits advice is included: fear of losing benefits is a major reason why clients may not want to seek employment, meaning that providing accurate information to inform and guide the client, including ensuring that they access in-work benefits for which they may be eligible, is essential.
- Rapid job search: the process of looking for a job starts within 30 days to show to clients that their desire to work is taken seriously.
- Systematic job development: ESs develop relationships with employers, learn about the work environment, employers’ work needs, the nature of job opportunities and assess whether their client may be a good job fit.
- Time-unlimited support: supports are individualised and continue for as long as
the client wants and needs the support and once a person has worked steadily for a period of time they discuss transitioning from IPS.\textsuperscript{8}

There is a fidelity model for IPS, meaning that the way in which these principles are implemented in a particular IPS service can be reviewed and scored against a 25-item fidelity scale.\textsuperscript{9} A maximum of 125 points can be achieved. The higher the score, the greater the fidelity of the particular IPS service and the greater expectation that job outcomes will be achieved for participants.

Many of the IPS principles could also work for people with drug and alcohol dependencies who are out of work and need support to find a job. PHE was commissioned by the joint Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC) Work and Health Unit to run a trial of IPS in alcohol and drug dependence community treatment services (hereafter the IPS-AD trial). The IPS-AD trial was the first large-scale multisite RCT of IPS for this client group.

1.2. Information about the trial

The aim of the trial was to understand the effect of receiving IPS support on the employment, treatment, health and, where relevant, criminal justice outcomes among people with alcohol and drug dependence. Participants in the treatment group received time-limited IPS pre-employment support for up to nine months and up to four months of in-work support if they secured employment. IPS was not adapted or amended from the key principles for the purpose of this trial or for the specific alcohol and drug dependence setting.

1.3. How the trial was conducted nationally

The IPS-AD trial was conducted in the following seven areas of England, which were selected following an open and competitive Expression of Interest (EOI) process:

1. Birmingham
2. Blackpool
3. Brighton and Hove
4. Derbyshire
5. Haringey
6. Sheffield
7. Staffordshire

Following selection, a process of intensive preparations followed for each of the trial areas, including frequent communication between PHE and each area, ethical approvals, contract negotiations, recruitment of IPS teams and the provision of IPS training for all new recruits.

The trial was launched on 7 May 2018. As of 30 September 2019, when recruitment ended, a total of 2,781 people had been screened. Of these 1,711 were eligible and consented to join the study and were randomly allocated to either the treatment arm (‘IPS’ plus treatment as usual [TAU]) or the control arm (TAU) in all three substance groups (opioids, only alcohol, other drugs).

1.4. How IPS was implemented at the site level

The IPS support was provided by teams of ESs who were based in treatment services within the trial site. ESs were members of treatment services teams, working alongside treatment services keyworkers (TSKs).\textsuperscript{10} Throughout the trial, TSKs were expected to discuss the trial
with all their eligible clients and to refer any who were interested and eligible onto the trial. Following a referral, the ES met with the referred client to discuss the trial further. After obtaining the client's consent to join the trial, the ES enrolled the client onto the trial, completed baseline questionnaires, and used a randomisation tool to allocate the client to either the treatment group (‘IPS’, meaning the client would receive IPS support) or the control group (‘TAU’, meaning the client would receive treatment as usual). Clients and the referring TSK were then informed about the randomisation result. Clients in the control group (‘TAU’) continued to receive the same support from the treatment services and from other services (including the Jobcentre Plus (JCP)) as was the case before being enrolled on the trial. Clients in the treatment group (‘IPS’) were placed on the relevant ES’ caseload and began to receive IPS support.

Throughout the trial, PHE communicated with IPS teams in the trial sites through the Principal Investigators (PIs), who also acted as Senior Employment Specialists (SESs) and team leaders in each trial site. PHE also liaised directly with treatment service managers (TSMs) and commissioners (Commissioners), when considered relevant and appropriate.

1.5. The evaluation

RAND Europe and CMH were commissioned by PHE in 2018 to conduct a process evaluation of the trial. The findings of the process evaluation are reported in this report. A parallel impact evaluation has been carried out by PHE.
Chapter 2. Methods

The process evaluation of the IPS-AD trial aims to document stakeholders’ and participants’ experiences of integrating IPS in local treatment services and to draw lessons from this. This evaluation draws on realist principles and combines both formative and summative elements to address the following nine evaluation questions (EQs):

1. What internal and external barriers and facilitators were there to the implementation of the IPS-AD trial in the specific context of treatment for alcohol and drug dependence, and what lessons could be learnt?

2. What day-to-day activities did the IPS service involve for participants and staff?

3. What expectations did participants have of their opportunities to obtain employment before and after the trial?

4. What were the barriers and facilitators associated with finding employment and to what extent did the trial address these?

5. What were participants’ positive and negative experiences of contact with existing local employment support services?

6. What were the organisational processes that enable IPS in the specific context of treatment for alcohol and drug dependence?

7. Were there participant characteristics that are best suited to IPS?

8. How can IPS best be implemented for the target population in the specific context of treatment for alcohol and drug dependence?

9. What are the contexts, mechanisms, and outcomes patterns that describe how IPS works in the specific context of treatment for alcohol and drug dependence?

2.1. Two Theory of Change models provided a guiding framework for the process evaluation

At the beginning of the evaluation, two Theory of Change (ToC) models were developed by the process evaluation team and set out working theories about the IPS service that were to be empirically tested in the evaluation:

- Figure 7 in Annex B1 depicts the ToC for the clients of the IPS service and illustrates the journey the clients take: from the moment they take up a referral to the IPS service, through to different elements and stages of the IPS support, up to the point when they (hopefully) find sustainable employment.

- Figure 9 in Annex B2 represents a ToC for local treatment services implementing the IPS-AD trial. It reflects a hope that, as a result of hosting the IPS service, it might become much more normal practice for alcohol and drug dependence treatment workers to discuss issues of work and employment with their clients, to refer to employment support, and to understand the therapeutic benefit of employment.

These two ToC models systematically set out the resources needed to implement the trial, the intended activities to be delivered, and the
theory that explains how these resources and activities will result in the desired outcomes. The ToC models also identify the assumptions that are necessary to achieve specific outcomes. While ToC models may seem linear, the evaluation team recognises that, in reality, the change process for each individual can vary considerably. As such, these models are designed to simplify the realities in order to make sense and create testable propositions.

The two ToC models therefore provided a guiding framework for the process evaluation. These models were initially used to guide the evaluation design, by identifying the processes to be explored, potential causal mechanisms, and key factors potentially contributing to change. In Section 4.9 we test the ToC models and initial hypotheses against the empirical evidence collected through interviews with institutional stakeholders and trial participants.

This produced revised ToC models which incorporate this learning (Figure 10, Figure 8).

2.2. The evaluation relies on semi-structured interviews, a documentation review, and analytical methods

The main data collection activity informing the process evaluation was a programme of 257 semi-structured interviews with trial stakeholders and participants at three different time points. Data from these interviews were supplemented by a documentation review that aimed to understand the IPS model, the treatment context, and the situation of each site and analytical methods.

Table 1 demonstrates how our responses to each EQ were informed by different methods.

<table>
<thead>
<tr>
<th>Section of the report (Evaluation question – EQ)</th>
<th>Semi-structured interviews</th>
<th>Documentation review</th>
<th>Analytical methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 3</td>
<td></td>
<td>Site documentation, administrative data, trial management information</td>
<td>Qualitative data analysis</td>
</tr>
<tr>
<td>Section 4.1 (EQ1)</td>
<td>Stakeholder interviews</td>
<td>Fidelity review reports</td>
<td>Qualitative data analysis</td>
</tr>
<tr>
<td>Section 4.2 (EQ2)</td>
<td>Stakeholder and participant interviews</td>
<td></td>
<td>Qualitative data analysis</td>
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<td>Section 4.3 (EQ3)</td>
<td>Stakeholder and participant interviews</td>
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<td>Section 4.4 (EQ4)</td>
<td>Stakeholder and participant interviews</td>
<td></td>
<td>Qualitative data analysis</td>
</tr>
<tr>
<td>Section 4.5 (EQ5)</td>
<td>Stakeholder and participant interviews</td>
<td></td>
<td>Qualitative data analysis</td>
</tr>
<tr>
<td>Section 4.6 (EQ6)</td>
<td>Stakeholder interviews</td>
<td></td>
<td>Qualitative data analysis</td>
</tr>
<tr>
<td>Section 4.7 (EQ7)</td>
<td>Stakeholder interviews</td>
<td>Fidelity review reports</td>
<td>Qualitative data analysis</td>
</tr>
</tbody>
</table>
2.2.1. The evaluation conducted 257 interviews across a range of stakeholders and participants

The process evaluation involved a programme of interviews which captured the perspectives of trial participants and institutional stakeholders. The programme of interviews took place over three waves in the trial (as shown in Table 2).

We conducted interviews with seven stakeholder groups across these three waves of interviews (see Table 3): SESs, ESs, TSMs, TSKs, Commissioners, JCP staff and employers.

We also conducted two waves of interviews with trial participants from both IPS and TAU groups from a range of sites and across all substance groups involved in the trial (see Table 4). The total number of interviews conducted in each wave can be seen in Figure 1.

Table 2: Timing and purpose of interviews conducted for this evaluation

<table>
<thead>
<tr>
<th>Wave</th>
<th>Purpose of interviews</th>
<th>Timing of interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wave 1: Readiness</td>
<td>Examine preparations for the set-up and implementation of the trial</td>
<td>July to August 2018</td>
</tr>
<tr>
<td>Wave 2: Transition</td>
<td>Explore early implementation challenges and solutions implemented</td>
<td>February 2019</td>
</tr>
<tr>
<td>Wave 3: Steady-State</td>
<td>Capture learning before the end of the trial</td>
<td>September to November 2019</td>
</tr>
</tbody>
</table>

SOURCE: RAND Europe and CMH
Table 3: Interviews conducted during the evaluation by stakeholder group

<table>
<thead>
<tr>
<th>Interviewee group</th>
<th>Wave 1</th>
<th>Wave 2</th>
<th>Wave 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(clients)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPS group</td>
<td>-</td>
<td>28</td>
<td>44</td>
<td>72</td>
</tr>
<tr>
<td>TAU group</td>
<td>-</td>
<td>22</td>
<td>27</td>
<td>49</td>
</tr>
<tr>
<td>Stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SES and ES</td>
<td>19</td>
<td>18</td>
<td>16</td>
<td>53</td>
</tr>
<tr>
<td>TSM and TSK</td>
<td>20</td>
<td>13</td>
<td>16</td>
<td>49</td>
</tr>
<tr>
<td>COM</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>JCP</td>
<td>7</td>
<td>2</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Employers</td>
<td>EMPL</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>52</td>
<td>89</td>
<td>116</td>
<td>257</td>
</tr>
</tbody>
</table>

SOURCE: RAND Europe and CMH

Table 4: Participant interviews conducted by substance group

<table>
<thead>
<tr>
<th>Interviewee group</th>
<th>Opioids</th>
<th>Alcohol</th>
<th>Other drugs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPS group</td>
<td>20</td>
<td>32</td>
<td>11</td>
<td>63</td>
</tr>
<tr>
<td>TAU group</td>
<td>29</td>
<td>20</td>
<td>9</td>
<td>58</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>49</strong></td>
<td><strong>52</strong></td>
<td><strong>20</strong></td>
<td><strong>121</strong></td>
</tr>
</tbody>
</table>

SOURCE: RAND Europe and CMH

Figure 1: Total number of interviews carried out by wave and area

SOURCE: RAND Europe and CMH
The majority of these semi-structured interviews were conducted face to face during site visits (with a small number of interviews with stakeholders conducted over the phone). The interviews were conducted using topic guides presented in Annex A. The topic guides were developed in a systematic way by: (i) operationalising each EQ by breaking it down into primary and secondary themes, (ii) drafting specific interview questions for each institutional stakeholder and participant group and mapping these against the themes and EQs, (iii) exploring some hypotheses from the ToC models to generate evidence for confirming or invalidating these. This approach allowed us to connect various elements of the evaluation into one coherent structure that ensured the data was collected in a consistent and methodologically rigorous way. Doing so enabled us to form a basis for analysing the data against each EQ.

2.2.2. Key documents, pieces of literature and fidelity review reports informed the process evaluation

A targeted documentation review was conducted to inform the process evaluation. This included a brief analysis of the (socio-economic) conditions and the specific arrangements to implement IPS in treatment services in each site. We reviewed IPS-AD documentation, data from the management information system, anonymised case studies put together by PHE and the trial sites, and the administrative data for each of the trial sites. This data can be found in section 3.

The evaluation team also drew upon the key pieces of literature on the IPS model, on the relationship between treatment and employment for people with alcohol and drug dependence, and on realist evaluation. This included drawing upon a targeted literature review of academic articles on IPS interventions, such as their design, implementation and outcomes, which was carried out as part of the ‘Evaluation of the Innovation Fund Health-led Trials’ project.

Finally, the evaluation team used information from the fidelity reviews reports for each site. All sites underwent two rounds of fidelity reviews conducted by the CMH and Social Finance. While fidelity reviews are intended to support sites in developing practice and improving the quality of their service, the evaluation team drew upon the resulting reports to supplement findings from interviews on the implementation of IPS in the drug and alcohol settings (see section 4.8).

Fidelity reviews assess the organisation and delivery of IPS by reviewing performance against the 25 item IPS fidelity scale that were developed from the 8 principles of IPS (see section 1.1 for more information on IPS principles and Table 5 for the fidelity scale). For each item, reviewers assign a score between ‘1’ and ‘5’, provide feedback, and issue recommendations. These scores are added together to determine the overall fidelity score of the service and form the basis of a fidelity report. A maximum of 125 points are possible and overall scores are classified as different levels of fidelity (see Table 5). The IPS fidelity scale used in the IPS-AD fidelity reviews was not adapted for the alcohol and drug dependence setting.

In order to assess the fidelity of each IPS service, fidelity reviewers spent a day at each site examining documentation, observing practices and interviewing a range of stakeholders (including the IPS team leaders, ESs, clients, partners, JCP staff, referrers from the treatment services and TSMs). Fidelity reviews are intended to support the sites in developing their practice and to improve the quality of service.
Table 5: The IPS Fidelity Scale

<table>
<thead>
<tr>
<th>Label</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exemplary Fidelity</td>
<td>115–125</td>
</tr>
<tr>
<td>Good Fidelity</td>
<td>100–114</td>
</tr>
<tr>
<td>Fair Fidelity</td>
<td>74–99</td>
</tr>
<tr>
<td>Not supported employment</td>
<td>73 and below</td>
</tr>
</tbody>
</table>


2.2.3. The evaluation drew on realist principles to understand how IPS works in the alcohol and drug dependence treatment context

In order to better understand how the IPS service works in the different contexts of alcohol and drug dependence treatment services, the evaluation drew upon a realist approach (see section 4.1.6). Accordingly, the evaluation focussed on key linked concepts for understanding how the IPS service works:

i. Mechanisms of the IPS service that (potentially) lead to expected effects

ii. Contexts (settings or conditions) in which IPS is introduced (and which may be relevant to the mechanisms)

iii. Outcomes patterns (or consequences) of IPS as a result of different mechanisms acting in different contexts that help to explain the variety of outcome patterns and identify what aspects of the intervention may work, in which circumstances, and for whom

2.2.4. There are some limitations that should be taken into account when interpreting the findings in this report

We carried out interviews with a wide range of local stakeholders in each of the seven areas. We consulted stakeholders who were closely involved and highly knowledgeable about the implementation process. These interviews, however, may not capture the full range of potential information available on the process of integrating IPS in local treatment services and experiences of IPS implementation and delivery. Regardless, we consider that the interview participants had knowledge of different stages and elements of preparing for, setting up and running the new IPS service, and were able to help us obtain a good understanding of these processes.

While we aimed to analyse the entire process of implementation and perceived effectiveness of the service, inevitably there were more data available on some aspects than others. These include the barriers and facilitators to implementation of the IPS-AD trial and the organisational processes that enable IPS in the context of treatment for alcohol and drug dependence. As a result, the analysis may be more heavily weighted on these aspects. In addition, we were unable to secure many interviews with employers who had been involved with the IPS-AD trial meaning that there is less data on their experiences and perceptions of the trial than was the case for other stakeholders.

Finally, the stakeholder interviewees in each site were primarily nominated by the SES in their role as PI. As the SES’s selection of interviewees appeared to be largely primarily based on availability and geographical location, we consider the risk of any selection bias in this regard to be low.

We carried out interviews with a large number of participants (121 participants) from all sites in Waves 2 and 3. When organising these interviews, we experienced low levels of engagement from participants following our initial contact. Furthermore, a number of those who agreed to take part in an interview did not turn up for our appointment. We therefore expect some self-selection bias among people who did attend an interview with us. We tried to mitigate this by ensuring we asked
stakeholders about different types of clients, including those who were not engaging with the service. Finally, we also note that we spoke to some participants who had worked with an ES for only a short period of time, meaning they had only a limited experience of the IPS service.

**All the interviews were semi-structured.**

This means that interviewees were not asked identical questions, leaving the interviewers the flexibility to tailor the discussion to the knowledge, experience and expertise of the interviewee. The interviews were carried out by multiple interviewers, meaning that styles of conversations differed slightly. We tried to mitigate against any bias this may have caused by practising the use of the standardised topic guides among the interviewers. In addition, all the findings from interviews are based on the knowledge and perceptions of the participants and it is not possible to verify every piece of information provided.

Interviews were recorded with interviewees’ permission with detailed notes taken and verified by listening to the recordings. While transcriptions of the interviews for qualitative coding would offer a more detailed and accurate material for analysis, this would have come with significant costs. The notes were analysed using a thematic approach that was structured according to a coding framework based on the primary and secondary EQs but also allowed flexibility to create new themes emerging from the data. We used NVivo 12 software to facilitate the analysis.

### 2.3. This report presents experiences and lessons from the implementation of the trial

This report brings together findings from all three waves of data collection. The report is aimed particularly towards treatment services planning to launch an IPS service in the future, but it provides information helpful for commissioners and funders of IPS services, those supporting people with alcohol and drug dependence into work, and the wider research community focusing on alcohol and drug dependence, treatment and employment.

The remainder of this report:
- Provides a brief overview of the trial sites (section 3)
- Responds to all EQs (section 4)
- Outlines key conclusions and recommendations from the process evaluation (section 5)
- Offers additional information in Annexes.
Chapter 3. **Overview of the context in each of the trial sites**

This chapter presents information on the context in each of the seven trial sites.

### 3.1. Contextual data for each of the trial sites

Table 6 provides an overview of the socio-economic characteristics of each trial site against the average figures for Great Britain as well as information on the treatment services provider and the IPS services providers. These statistics illustrate the different contexts in which the IPS-AD trial is implemented, and the diverse challenges faced by the sites. The diversity of the sites created complexity for the evaluation, thus ensuring that use of realist principles that focus on contexts and mechanisms even more important.

Figure 2, Figure 3, and Figure 4 present information on the percentage of opiate, non-opiate and alcohol clients who successfully completed treatment in 2018 for each site.
### Table 6: Overview of site characteristics

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Source</td>
<td>GOV.UK</td>
<td>ONS</td>
<td>ONS</td>
<td>GOV.UK</td>
<td>GOV.UK</td>
<td>Online research</td>
<td>PHE, EOIs</td>
<td></td>
</tr>
<tr>
<td>Birmingham</td>
<td>739,719</td>
<td>0.80</td>
<td>65.2 (72.5/58.0)</td>
<td>8.2 (8.9/8.3)</td>
<td>14.2</td>
<td>14.2</td>
<td>Charity</td>
<td>Charity (5 ES)</td>
</tr>
<tr>
<td>Blackpool</td>
<td>87,496</td>
<td>0.85</td>
<td>72.8 (74.3/71.2)</td>
<td>5.6 (5.3/6.2)</td>
<td>23.5</td>
<td>36.2</td>
<td>Charity</td>
<td>Local authority (3 ES)</td>
</tr>
<tr>
<td>Brighton and Hove</td>
<td>205,971</td>
<td>0.84</td>
<td>76.2(79.0/73.3)</td>
<td>3.8 (2.6/4.3)</td>
<td>10.0</td>
<td>16.6</td>
<td>Partnership between 4 charities and an NHS trust</td>
<td>Charity (3 ES)</td>
</tr>
<tr>
<td>Derbyshire</td>
<td>494,179</td>
<td>0.72</td>
<td>78.5 (81.9/75.2)</td>
<td>2.8 (#/4.0)</td>
<td>7.3</td>
<td>13.1</td>
<td>Partnership between a charity and an NHS trust</td>
<td>Private sector (4 ES)</td>
</tr>
<tr>
<td>Haringey</td>
<td>194,650</td>
<td>0.48</td>
<td>76.9 (79.4/74.2)</td>
<td>4.1 (#/#)</td>
<td>10.8</td>
<td>13.9</td>
<td>Partnership between 3 charities and an NHS trust</td>
<td>Charity (3 ES)</td>
</tr>
<tr>
<td>Sheffield</td>
<td>383,240</td>
<td>0.76</td>
<td>74.0 (77.5/70.4)</td>
<td>4.2 (4.1/4.5)</td>
<td>10.8</td>
<td>14.2</td>
<td>NHS trust</td>
<td>NHS Trust (4 ES)</td>
</tr>
<tr>
<td>Staffordshire</td>
<td>543,664</td>
<td>0.77</td>
<td>79.1 (82.9/75.2)</td>
<td>3.1 (3.4/#)</td>
<td>7.1</td>
<td>11.2</td>
<td>Partnership between 4 charities and an NHS trust</td>
<td>Charity (4 ES)</td>
</tr>
<tr>
<td>England</td>
<td>35,457,660</td>
<td>0.87</td>
<td>76.0 (80.2/71.8)</td>
<td>3.9 (4.1/3.7)</td>
<td>9</td>
<td>13</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Source:** ONS, n.d.; PHE, 2019a.

**Notes:** * The density figures represent the ratio of total jobs to population aged 16-64. Total jobs include employees, self-employed, government-supported trainees and HM Forces.
† % are for those aged 16-64.
‡ % are for those aged 16 and over (% is a proportion of economically active people).
# Sample size was too small for reliable estimate.
Figure 2: Percentage of opiate clients who successfully completed drug treatment (2018)

<table>
<thead>
<tr>
<th>Site</th>
<th>Birmingham</th>
<th>Blackpool</th>
<th>Brighton and Hove</th>
<th>Derbyshire</th>
<th>Haringey</th>
<th>Sheffield</th>
<th>Staffordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site average</td>
<td>5.4%</td>
<td>4.2%</td>
<td>8.1%</td>
<td>4.1%</td>
<td>7.1%</td>
<td>2.9%</td>
<td>5.3%</td>
</tr>
<tr>
<td>England average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SOURCE: PHE (2019, b).

Figure 3: Percentage of non-opiate clients who successfully completed drug treatment (2018)

<table>
<thead>
<tr>
<th>Site</th>
<th>Birmingham</th>
<th>Blackpool</th>
<th>Brighton and Hove</th>
<th>Derbyshire</th>
<th>Haringey</th>
<th>Sheffield</th>
<th>Staffordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site average</td>
<td>37.9%</td>
<td>22.7%</td>
<td>37.2%</td>
<td>29.5%</td>
<td>35.9%</td>
<td>23.5%</td>
<td>34.3%</td>
</tr>
<tr>
<td>England average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SOURCE: PHE (2019, b).

Figure 4: Percentage of clients who successfully completed alcohol treatment (2018)

<table>
<thead>
<tr>
<th>Site</th>
<th>Birmingham</th>
<th>Blackpool</th>
<th>Brighton and Hove</th>
<th>Derbyshire</th>
<th>Haringey</th>
<th>Sheffield</th>
<th>Staffordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site average</td>
<td>40.4%</td>
<td>28.2%</td>
<td>40.5%</td>
<td>35.2%</td>
<td>42.6%</td>
<td>27.2%</td>
<td>34.5%</td>
</tr>
<tr>
<td>England average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

SOURCE: PHE (2019, b).
3.2. Information about the IPS service in each site at the start of the trial

**Birmingham**

There were five ESs in Birmingham who were employed by Change Grow Live (CGL). While initially most of the ESs were based in the central CGL office, as the trial proceeded, they moved to be co-located with each of the four new area teams across the city instead. This set-up was also considered a way to help the service deal with the large scale of the treatment services. With a client base of 6,000 divided across five (subsequently restructured to four) areas, the new set-up ensured that each ES would have about 1,000 people to consider.

The implementation of IPS-AD was overseen by a steering group, which included some external organisations and representatives from organisations involved in another IPS trial in Birmingham. An IPS forum has also been set up for the wider area.

**Blackpool**

Three ESs were employed by Blackpool Council and based in the treatment provider, Delphi Medical Consultants Ltd. The treatment service comprised four sites: Connect (the entry-point for all service users), Dependence (which offers detox and rehabilitation), Freedom (offering intensive recovery programmes) and Harrowside (a prescribing administration site). Each centre offers services to individuals from the three main dependency groups: opiates, alcohol and non-opiates. ESs operated in two main locations by being based in the Connect centre and visiting the Dependence centre on a regular basis.

There were two management and governance groups that supervised the implementation of the IPS service in Blackpool. A strategic steering group met quarterly and was composed of a public health commissioner, the strategic lead for economic development, the JCP partnership manager and representatives of other services. An operational group brought together those who directly implemented the service (including the SES and TSM) and met monthly.

**Brighton and Hove**

There were three ESs who operated in the main locations of the Pavilions treatment services in Brighton and Hove. A steering group provided strategic oversight of the implementation of IPS in the area. The members of the steering group were the local authority public health commissioner and director of public health, senior partnership managers from JCP, representatives from Brighton Business Improvement District, probation and housing support, and a senior manager from Pavilions responsible for external partnerships. The steering group focused on topics such as maximising employment opportunities in Brighton and Hove, resolving operational issues and engaging with local employers. Additionally, Pavilions had a Partnership Strategic Governance Group which met quarterly and reported on IPS progress.

**Derbyshire**

Four ESs were employed by Intuitive Thinking Skills, which is part of Derbyshire Recovery Partnership (DRP). ESs were attached to geographical areas, and the SES was primarily based in the Chesterfield office – the biggest treatment service base in the region. Given the size of the county, certain localities were prioritised to limit the travel time between sites to no more than one hour, thereby making the coverage feasible for the team.

The trial was governed by a stakeholder steering group chaired by the local authority commissioner, while the day-to-day oversight
was by an Intuitive Thinking Skills manager who maintained contact with the SES.

**Haringey**

There were initially three substance treatment service providers in Haringey: The Grove, HAGA and Haringey Recovery Service. Two ESs (of the three originally intended) operated across these three providers: one ES was based in The Grove and another in Haringey Recovery Service. Both visited HAGA and the provider in which they were not based on a regular basis. ESs were employed by St Mungo’s and placed in service centres run by other providers: BEH-MHT, Blenheim, and HAGA.

An operational health and employment steering group provided advice for the IPS-AD trial in Haringey. Additionally, there was a local steering group composed of the managers from the three alcohol and drug dependence services.

**Sheffield**

There were three substance teams in the Sheffield Health and Social Care NHS Foundation Trust (SHSC): the alcohol service and non-opiates drugs service were co-located, while the opiates service was in a separate building. All are based in the city centre of Sheffield. In addition to the SES, there were three ES based in each of the three substance teams.

The implementation was governed by a steering group comprising the local authority commissioner, a supporting commissioning officer, TSM, SES, representatives from JCP, and the research lead for the Trust.

**Staffordshire**

Addiction Dependence Solutions (ADS) leads the One Recovery partnership that provides services and operates in treatment centres and recovery hubs throughout Staffordshire and hosted the IPS team of three ESs and a SES. ESs were posted across the treatment service teams and worked from across three treatment bases covering six outreach sites: Stafford, Cannock, Leek, Newcastle-under-Lyme, Burton upon Trent and Tamworth.

A steering group (chaired by the local authority commissioner and including a representative from JCP) has been set up to provide oversight and direction to the IPS-AD trial in Staffordshire.
Chapter 4. Responses to the evaluation questions

4.1. Barriers and facilitators to the implementation of the IPS-AD trial in the specific context of treatment for alcohol and drug dependence

Box 1: Summary findings to EQ1 (what internal and external barriers and facilitators were there to the implementation of the IPS-AD trial in the specific context of treatment for alcohol and drug dependence, and what lessons could be learnt?)

- The IPS-AD trial was implemented across seven diverse locations
  - IPS was delivered to fair or good fidelity
  - Throughout the trial, local barriers and facilitators remained important
- Having ESs with the skills and backgrounds that facilitated the building of personal relationships with keyworkers and clients was important in implementation
- Staff turnover was occasionally a challenge for sites
- Training opportunities commissioned by PHE and from other sources were generally considered helpful (with subsequent training even more useful)
  - Throughout all waves, a number of other training and upskilling opportunities were provided outside of the trial context
- The process of receiving referrals became easier throughout the course of the trial as a result of improved integration and ongoing efforts by ESs and treatment services management
  - In IPS-AD, all clients who met the trial eligibility criteria and were interested in finding paid work should have been referred
  - Ongoing barriers throughout the trial included keyworkers’ discretion, reluctance to refer due to concerns about client readiness, concern about randomisation, and competing priorities
  - The IPS teams used different strategies to overcome these barriers, which had to be maintained throughout the trial’s lifetime
  - Enabling factors that helped encourage referrals included having simple processes for referrals and the having the IPS team co-located in treatment services teams
- Client disengagement with IPS was a continual challenge throughout the trial
  - No one clear reason or reasons emerged as to why clients were not engaging with the service
  - ESs have used a number of strategies in an attempt to tackle low engagement rates, drawing on both the IPS model and other innovative approaches.
4.1.1. The IPS-AD trial was implemented across seven diverse locations

IPS was delivered to fair or good fidelity. The IPS-AD sites underwent two rounds of fidelity reviews: round 1 was conducted in September 2018 (just after evaluation interviews were conducted in Wave 1) and round 2 was conducted in July-November 2019 (at a similar time to Wave 3 evaluation interviews). Given that all sites were new to IPS provision, IPS fidelity reviewers would expect that services improve over time. This does not, however, mean that services can only score higher in subsequent reviews; lower scores in subsequent reviews may illustrate organisational or staff changes that are experienced by new, as well as long-established, services.

In these two rounds of review, all IPS-AD services demonstrated improvement in their fidelity over time. Table 7 provides an overview of scores achieved by the seven services against each item of the IPS 25-item fidelity scale in the first and second round of reviews. As demonstrated, in all sites, fidelity review scores improved over the course of the trial, with five of the seven sites reporting ‘Good’ fidelity by Round 2 of reviews.

Further information about the IPS 25-item fidelity scale can be found in section 2.2.2 and the scale itself can be found in Table 5. More detailed analysis of the scores received by individual sites is located in section 4.8.

Throughout the trial, location-specific barriers and facilitators remained important. Some specific challenges identified in the initial set-up phase (Wave 1) were a result of organisational set-up and the local context. Interviewees from Derbyshire noted the complexities of collaboration within the multi-organisation partnership structure of the treatment services. One interviewee in Sheffield felt that the recruitment procedures that had to be followed within the NHS-operated treatment services took a relatively long time due to the need to follow various regulations in place around the recruitment of NHS staff. A few stakeholders across different sites reported that the roll-out of the Universal Credit in their local area had affected the levels of engagement that JCP had with the IPS services, reportedly because this change took up a considerable amount of JCP resources.

Table 7: Fidelity scores received by all sites in the IPS-AD trial in Round 1 and 2

<table>
<thead>
<tr>
<th>Site</th>
<th>Birmingham</th>
<th>Blackpool</th>
<th>Brighton and Hove</th>
<th>Derbyshire</th>
<th>Haringey</th>
<th>Sheffield</th>
<th>Staffordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 1 (2018)</td>
<td>88 (Fair)</td>
<td>84 (Fair)</td>
<td>84 (Fair)</td>
<td>97 (Fair)</td>
<td>77 (Fair)</td>
<td>96 (Fair)</td>
<td>77 (Fair)</td>
</tr>
<tr>
<td>Round 2 (2019)</td>
<td>97 (Fair)</td>
<td>104 (Good)</td>
<td>103 (Good)</td>
<td>107 (Good)</td>
<td>88 (Fair)</td>
<td>107 (Good)</td>
<td>111 (Good)</td>
</tr>
<tr>
<td>Change over time</td>
<td>Improved</td>
<td>Improved</td>
<td>Improved</td>
<td>Improved</td>
<td>Improved</td>
<td>Improved</td>
<td>Improved</td>
</tr>
</tbody>
</table>

SOURCE: Based on CMH & Social Finance fidelity reports (unpublished).
As discussed in section 4.6.2, the integration of IPS services with treatment services is a key principle of IPS. In the IPS fidelity scale (Table 5), the physical co-location of ESs with the treatment teams, the sharing of treatment plans and recovery monitoring systems with the treatment teams, and the treatment of IPS workers as part of the treatment teams are important ways in which this integration is demonstrated. Throughout the trial, one stakeholder from Haringey noted that the structure of the treatment services and how the IPS workers were integrated with these had posed significant and site-specific challenges to achieving integration. The hosting treatment partnership comprised three different services with different contractual agreements between each other and with commissioners,\textsuperscript{28} the complexity of which were compounded by significant organisational changes affecting two of the service providers. Some interviewees felt that these factors had led to challenges for ES in promoting IPS referrals\textsuperscript{29} and may have also weakened TSKs’ motivation to make referrals.\textsuperscript{30} In addition, another location-specific challenge in this site was that the IPS service was operated by a fourth and separate organisation that employed the IPS staff (rather than the treatment services).\textsuperscript{31} As a result, ESs in Haringey reported that they had experienced some initial problems with gaining access to all the IT systems and databases. These issues were reportedly eventually resolved by the second round of interviews, six months after the start of the trial.\textsuperscript{32}

Some interviewees from Haringey, who were consulted in Wave 3 (over a year into the trial’s implementation), also felt that the treatment services saw IPS as less of a priority, compared to other sites where IPS teams were employed directly by treatment services.\textsuperscript{33} The same stakeholders reported that lines of accountability between the treatment services, the organisation employing the IPS staff, the COM and PHE were sometimes unclear due to the number of different bodies and organisations involved. Stakeholders reported that they felt that the PI was often the only link between managers in these four bodies (PHE, commissioners, treatment services, and organisations employing the IPS staff). When the PI had not been active in attempting to keep all parties informed and connected to one another, interviewed stakeholders considered that this had led to some challenges in terms of treatment services senior management and commissioners recognising issues and addressing problems with the IPS service.\textsuperscript{34} In Haringey, such challenges were compounded by staff turnover in the IPS team which meant that, for a period of time, one service was left without an ES and both ESs had only limited supervision from the organisation that employed them.\textsuperscript{35}

Some positive aspects, however, of having IPS teams integrated in multi-agency treatment partnerships were recognised as well. Some interviewees from Haringey and Derbyshire felt that it was helpful that treatment services staff were used to working in partnerships\textsuperscript{36} and that having a range of partners brought a breadth of experience, which helped the implementation of the trial and integration of IPS.\textsuperscript{37}

‘Because we are working with different organisations, we are used to working in partnership and we are used with the concept that everybody brings something to the table and all the things are valued. Together [...] the combination of different elements is something really important.’

(COM 1)

In Sheffield, where the treatment services comprise a number of different services in one place but with a single provider, interviewees also considered such an arrangement to be useful. This was because it made it easier for the IPS team to liaise with all different treatment services staff and engage with clients.\textsuperscript{38}
Interviewees reported that geographical factors (including urban or rural locations) could act as barriers and facilitators. One interviewee in Blackpool noted that being based in a compact area meant it was easier for the ES team to share employers, contacts and work. Conversely, some interviewees from two sites reported specific geographic challenges. Interviewees from Derbyshire in both Waves 1 and 2 felt that the structures and set-up of the IPS service were not always easily adaptable to the large and rural nature of the county. This was because ESs had to work across several rural locations and could not be physically present in some of the more rural offices very frequently. As a result, several interviewees felt that rural locations had resulted in limited integration between the IPS team and keyworkers in rural offices. Specifically, it was felt that this had an impact on the number of referrals that TSKs made to the IPS-AD trial. Others considered that the large and rural nature of Derbyshire had created some extra work for treatment services during the initial set-up of the trial because of the need to adapt the expected systems to be feasible given the considerable distance between sites and clients. Interviewees in Staffordshire, another rural county, also described similar challenges, with ESs covering very large areas.

ESs in these more geographically remote areas reported that they had responded to this challenge by meeting clients in community-based settings more frequently, as is already good practice in IPS. Despite being able to make these adjustments, ESs considered that the rural nature and long travel times between different services in Derbyshire still made it more difficult for ES to meet clients, to learn from other ESs and to work collaboratively.

There were also some other site-specific factors that affected the IPS delivery in each area. For Sheffield and Birmingham, the state of the local economy was perceived to be a facilitator, with the availability of many suitable jobs. Contrastingly, the rural nature of Derbyshire and the high concentration of students – who may often compete with treatment clients in particular employment sectors – in Brighton were both considered challenges.

4.1.2. Having ESs who were able to facilitate the building of personal relationships with keyworkers and clients was important in implementation

The ESs recruited to the IPS-AD trial were broadly drawn from two profiles: (i) those who had previous experience in supporting individuals misusing drugs and alcohol, but who had not been heavily involved in employment support; and (ii) those who had previously worked in employment support (sometimes for vulnerable groups), but who had limited experience of the treatment service context. As a result, ESs with employment backgrounds had to learn how to best offer support to the specific client group, while those from a treatment services backgrounds learned how to offer employment support and engage with employers.

During Wave 2 and 3 interviews, many interviewees felt that having the ‘right’ people as ESs was an important facilitator in appropriate delivery of the IPS-AD service. This section explores what interviewees reported were important in terms of ESs’ skills, competencies and experiences.

‘You need ES who are going to be in the face of the TSKs in the nicest possible way and talking to them about the trial and educating them but also being really flexible and understanding.’ (TSM 2)

These skills overlap considerably with the skills that ESs needed to carry out their day-to-day activities in liaising with clients (see section 4.2.1).
In addition, many interviewees considered that it was important for ESs to quickly gain a good understanding of the alcohol and drug dependence treatment services’ client group. Understanding clients was important because it ensured that ESs knew how to work with these clients and understood the challenges they faced, and understood the treatment services and the role of the keyworker.

Having this level of understanding also helped ensure that keyworkers trusted that ESs could help and support their clients. This, in turn, facilitated both referrals and integration and helped ES work better with clients. In some cases, having ESs with a background in drug and alcohol services meant that keyworkers and individual ESs already knew each other prior to the trial. This was felt to have facilitated both the integration of the IPS service with the treatment services and for facilitated working with the clients.

While most interviewees considered that ESs had a good understanding of the client group, others identified that this was a gap for them and for their team. As outlined in section 4.1.4, this was an area where additional training was frequently sought out.

In addition, some SESs also considered that it was important to have a varied ES team with people with different skills and previous experiences who could learn from each other. The mix of previous experiences included ESs with backgrounds in criminal justice, ESs with employability backgrounds, and ESs with experience in mental health, and drug and alcohol treatment services. In addition, one interviewee felt that having a mixture of ESs with lived experience of alcohol and drug dependence and local knowledge, and more formal education qualifications was helpful.

In addition to their background, an ES’s skills were also identified as important for ensuring that they were able to integrate with the treatment services. These skills included:

- **Good people skills** to facilitate integration and help keyworkers to buy into the trial
- **Being flexible and willing to learn**
- **Being approachable and happy to talk to people** and understanding
- **Being a good fit for the team** and able to build good personal relationships

### 4.1.3. Staff turnover was occasionally a challenge for sites

As ESs’ backgrounds and skills could be important in building relationships with keyworkers, some interviewees felt that personnel changes in the ES roles was a challenge because it made it harder to sustain relationships. Specifically, changes in the SES role in Birmingham were considered disruptive; although the management solution found was felt to benefit the service overall. Yet, while some staff turnover was seen in other sites, including Derbyshire and Sheffield, interviewees from these sites did not report disruption.

In Haringey, a few interviewees felt that personnel changes in the ES team and within the PI role had contributed to challenges in communication between trial partners. In particular, one stakeholder reported that changes in personnel had made collaboration with JCP more difficult.

Recruitment of ESs was often challenging, with a number of interviewees in Wave 1 reporting difficulties in finding people with suitable skills and sufficient experience. Others, however, reported having been able to recruit easily for the positions.

### 4.1.4. Training opportunities from the trial and from other sources were generally considered helpful (with subsequent training even more useful)

As part of the IPS-AD trial, PHE commissioned core training for all ESs. This included:
• a continuing professional development (CPD) accredited 2-day IPS training course provided by the CMH
• a 12-week online IPS practitioner skills course provided by the IPS Employment Center in the US.

In all three waves, ESs who were interviewed were asked about their experiences of any training they received throughout the trial (whether commissioned by PHE, organised by the local IPS service, or organised by the relevant treatment services organisation).

In Wave 1, many ESs reported that the core in-person training they had received from the CMH was helpful, but had some reservations about the core online training provided by the USA IPS Employment Center. Some felt the online training was too early in their practice to be useful, or that they simply did not learn much from it. A few, however, found this training helpful. A number of Wave 2 interviewees also reflected that, in retrospect, the initial training from the IPS Employment Center had not proven to be very useful in their day-to-day practice, and that more skill building in the area of employer engagement was needed.

In addition to this initial training, and in response to reported needs, PHE arranged for ESs in all sites to attend individual training sessions with an external IPS consultant on the topic of employer engagement. Many interviewees in Wave 2 and Wave 3 reported that this additional employer engagement training was very useful. This was because:
• Interviewees felt that it provided a refresher of earlier skills
• Training included new perspectives on IPS and provided them with specific tools to use in employer engagement

• It gave ESs confidence on how to engage with employers and build long-term relationships.

Some interviewees felt that this training came at a more helpful time in the trial than initial training had, as it allowed ESs to draw on their own experience and practice in a helpful way. One SES reported that it was beneficial in helping their team understand how they could undertake employer engagement, despite not having clients’ permission to disclose matters relating to health and treatment status (see section 4.2.5).

Many interviewees from both Wave 2 and 3 also found PHE ‘away days’ a helpful experience. Attending these away days boosted interviewees’ morale, offered useful sessions, allowed ESs the chance to practice and develop existing skills, and included opportunities to speak to and learn from other ESs in other sites.

Throughout all waves, a number of other training and upskilling opportunities were provided outside of the trial context.

By Wave 3, with the exception of the PHE away days, no additional training was provided at the central level. SESs, however, were expected to seek out and access relevant continuing professional development opportunities for ES teams whenever this was considered helpful and appropriate. As a result, several ESs from all sites reported accessing training provided outside of the trial context. For example, a number of interviewees reported that they had used an e-learning course from IPS Grow, which was a helpful refresher of IPS principles and employer engagement.

Beyond IPS specific support, some interviewees reported that they had attended helpful training on alcohol and drug dependence and the needs of this specific client group. Training attended included
sessions on drug and alcohol awareness and on the challenges that clients on low doses of substitute prescribing face. Stakeholders noted that the alcohol and drug dependence awareness training was especially useful for those ESs without prior experience working with this client group. In one site (Derbyshire), the COM arranged support from a clinical psychologist working with the local authority on how to improve client engagement with the client group, which was considered helpful (see section 4.1.6). In most cases, this additional training was sought out by IPS teams and provided or paid for by treatment services or a partner organisation, such as the NHS or the local authority.

Some ESs reported that they had also received training about other issues that often relate to this particular client group, such as mental health, criminal justice, and benefits, which were generally considered helpful. These sessions were generally organised by the IPS team leader or by treatment services and included sessions on suicide and self-harm prevention, promoting positive mental health, supporting people with criminal convictions into work, trauma-informed practice, and domestic violence. Other opportunities included mentorship relationships, training on how to provide benefits calculations, and training on Universal Credit.

Beyond organised training sessions, a few interviewees reported receiving support and upskilling from their managers and colleagues through group supervisions. SESs in particular also found talking to other SESs on the trial to be a useful forum for learning, especially when there was little other IPS support available in the local area. One SES reported receiving mentoring from another organisation and benefiting from conversations with individuals at PHE, while another reported regular meetings with a person from a local IPS Centre of Excellence. Two ESs also reported receiving support from IPS Grow regional leads, in the forms of phone conversations and from useful resources that their SES passed onto the team.

A few interviewees reported that they did not feel the need for more training, while others identified ongoing training needs. Two ESs, both of whom were relatively new at the time of interview, felt that more training in IPS would be helpful and that more opportunities to shadow and learn from other sites would benefit their practice. Other ESs felt that more training focusing on the specific client group would be helpful and that more practice in conducting motivational interviewing would be helpful because of the nature of the client group.

4.1.5. The process of receiving referrals became easier throughout the course of the trial as a result of improved integration and ongoing efforts by ESs and treatment services management

TSKs were asked to refer all clients who met the trial eligibility criteria and who were interested in the finding paid work. As outlined in section 1, one of the key principles of IPS is zero exclusion – that eligibility to receive IPS support is based purely on client choice, with every person who wants to work being eligible for IPS, regardless of their diagnosis, symptoms, work history, or other factors. In the IPS 25-item fidelity scale, one item examines how far services meet this principle. High fidelity sites must demonstrate that all clients who are interested in working have access to IPS services and that TSKs do not use any screening criteria other than client interest when deciding whether or not to refer an individual.
In the IPS-AD trial, a few additional trial eligibility criteria were applied. In order to be referred, participants had to meet a range of inclusion criteria, including being:

- Aged between 18 and 65
- Enrolled in alcohol and drug dependence treatment for at least 14 days
- Unemployed or economically inactive for at least six months.

Participants were ineligible to join the trial if they were:

- Currently receiving detoxification treatment
- Having a clinically significant severe mental health, intellectual disability, organic brain disease or physical disability that would prevent them from accepting IPS
- Planning, or had planned, suicide in the past month, or made a suicide attempt in the last six months
- Involved in legal proceedings that were likely to result in imprisonment
- Enrolled in another IPS trial within the last six months or had previously enrolled in the IPS-AD trial.

When referred to the trial, and subject to consent, participants were allocated into either the treatment group or the control group. TSKs, regardless of their opinion about whether or not clients were ready to work, were expected to offer participation in the trial to all clients who met the eligibility criteria, and to then refer any of these clients who expressed interest.

Barriers throughout the trial included keyworkers’ reluctance to refer due to concerns about clients’ readiness, dislike of randomisation, and competing priorities. Across all waves of evaluation interviews, interviewees from different stakeholder groups reported that keyworkers used their discretion when deciding whether or not to tell a client about the IPS-AD trial or refer a client to the IPS-AD trial. This was a persistent challenge in implementing the trial successfully.

On the whole, stakeholders reported that keyworkers were reluctant to refer clients who they considered were not ready for work. In interviews with the evaluation team, many keyworkers expressed that they did not believe clients could work or were ready for work. Other keyworkers reported that this was because they did not believe that IPS would be helpful. This is well-illustrated in one site (Derbyshire), where a recent development in the organisation of caseloads had resulted in keyworkers’ caseloads being rated ‘red’, ‘amber’ or ‘green’. Stakeholders reported that clients in the ‘red’ group were considered as ‘clients not ready for work’, regardless of the IPS principle that all clients can access support if they are willing to.

‘It has been harder to change the hearts and minds of keyworkers, who are much more focused on treatment and tend to think that people have to get well before they will be ready to engage. But we have promoted that it’s good to give people aspirations, even if you are not sure they are ready.’ (COM 3)

Keyworkers felt clients were not ready to work when they had high drug use, a generally chaotic life, mental health problems, or other issues that were considered more important and pressing. Some keyworkers did not refer clients because of their views about the role of employment in recovery or because they were concerned that thinking about employment would be too risky for their clients. There was little consensus on characteristics of keyworkers who were reluctant to refer clients. Some interviewees thought that clinical treatment services staff (especially those from the NHS) were more likely to be resistant to referring clients to IPS than non-medically trained recovery workers.
Others reported that clinical staff in their site were more likely to refer than other treatment services staff.  

‘There will always be [keyworkers] willing to have a conversation from the start and [keyworkers] who are not happy [to do it] and this hasn’t changed.’ (SES 4)

In particular, however, Wave 3 interviewees from all sites reported that while keyworkers had continued to use their own judgement when deciding whether or not to refer, their use of discretion had lessened over time. Some interviewees attributed this shift in practice to the efforts made by the ESs to persuade keyworkers to refer. Particularly effective measures reportedly included: maintaining a dialogue with keyworkers about the role employment could play in recovery; reminding keyworkers of the criteria for referral; and generally building personal relationships and trust with keyworkers. As a result of these measures, understanding of IPS support among some (but not all) keyworkers was felt to have evolved.

‘IPS has won over people who would never have thought about it before because they see themselves as a recovery service.’ (TSM 5)

‘I understand that IPS is not only to offer a job but to offer a meaningful job to the person so this is how I understood the project; having a meaningful job will help the clients stop taking drugs and engaging in a more structured life. So I talked to them as that in terms of doing a job that it would be interesting to them. If you would like to pick a job and what would it be? And if you had someone to help you with that, would you take it? I think it is a motivational work to help them look at it from their own interest.’ (TSK 7)

‘[There’s] nothing negative about IPS. It’s positive and person-centred, it succeeds because of the level of support and understanding their personal skills and aspirations. Our IPS team are good at working with people’s aspirations and they are also responsible about the safety aspect, if people are on methadone, etc. The team are experts in their field and have become experts in our client group too. They are brilliant at that and I couldn’t praise them high enough. They have supported and educated our team about employment.’ (TSM 8)

Others felt that a visit by PHE and training provided to TSKs had been important factors in bringing about change. One keyworker reported that while they had previously only referred more stable clients, after the ES had explained that IPS was suited for clients at all points in the recovery journey, they now referred more widely. Two other keyworkers who were interviewed considered that one of the main things they had learnt from the trial was that anyone who was interested in employment should be referred and supported. Another interviewed keyworker, however, explained that they had become more selective about who they referred to the trial after seeing that some clients who had been ready for employment.

‘[Keyworkers] do have more information now; they get it through their clients working with me, they trust us now and know that we have the clients’ interest at heart.’ (ES 9)

‘I think for some people have jumped quickly into employment; quicker than I thought they would do. Some people after the first assessment said that they don’t want to do it anymore and this has a little bit affected the way I refer to the IPS. Initially I referred quite a few people in the IPS but now I am more selective.
having seen the process and how it works.’ (TSK 10)

The two-arm nature of the trial also acted as a barrier to referrals throughout the implementation period. As outlined above, after referral to the IPS-AD trial, participants were randomised into either the treatment group or the control group. Many interviewees reported that keyworkers were not always comfortable with the idea of the control group into which their clients might be randomised. Keyworkers felt that being randomised into the control group would not help their client, did not understand why there was a control group, or were discouraged by seeing a high proportion of clients being randomised into the control group.

While one SES felt that keyworkers’ concerns about randomisation had not lessened, others felt that this barrier was being overcome over the course of the trial. This change was perceived to have occurred as keyworkers gained understanding about the reasons why there was a control group and were given more information about the trial.

Many interviewees also reported that keyworkers’ competing priorities acted as a barrier to further referrals. The fact that keyworkers had high caseloads, a pressurised job, and that treatment services often had other ongoing changes and developments affected how frequently keyworkers remembered to refer clients to the IPS-AD trial. As a result, ESs had to consistently remind and be a visible presence to treatment staff for referrals to continue.

At the beginning of the trial, a few interviewees from two sites felt that a lack of visible buy-in from treatment services management had led to difficulties in ensuring that there were high levels of referrals. As some treatment managers reportedly did not help to spread the message to keyworkers about the need to discuss referrals to IPS-AD with all eligible clients, a number of keyworkers did not see the trial as a priority and ES felt that they had to promote the service without much senior support. In one site (Birmingham), this issue was felt to be resolved by a number of changes: including a new IPS team leader, a relocation (where ESs moved to the offices where the treatment services teams were located), and a change in treatment services management:

'We are told now that IPS is important to the company but it wasn’t treated that important at the start, the keyworkers were told it was an initiative and they could refer, but no-one was told to refer, it was down to us to persuade everybody and it felt like a losing battle, going to team meetings and saying “Please refer, please refer” and literally we were begging people. Then, when we asked how many referrals we got this week by management, they said “why is that, what are you doing wrong?” but we were only as strong as the keyworkers.’ (Birmingham stakeholder 1)

In Wave 3, interviewees from a number of sites reported that referrals had slowed towards the end of the recruitment period because, as might be expected, there were fewer eligible clients who had not already been asked about or enrolled upon the trial. Some interviewees reported that almost all clients in the treatment services had been asked about whether they would like to be referred to the trial at least once. This created some difficulty in maintaining a steady stream of referrals.

A few interviewees reported that there were occasional issues with the quality of referrals: that keyworkers sometimes referred clients who did not meet the trial eligibility criteria or who were not keen to attend a meeting with an ES or did not want to enrol on the trial after learning more about the trial. This was at least partly attributed to ESs and
TSKs feeling pressured to refer all clients regardless of suitability by overly ambitious referral targets. Strategies to combat this included ESs reminding TSKs of clients’ eligibility and suggesting that TSKs ask more probing questions about clients’ interest in employment.

The IPS teams used different strategies to overcome these barriers to referrals, which had to be maintained throughout the trial’s lifetime.

Throughout the trial, many ESs reported that ensuring referrals were made to the IPS-AD trial had been difficult and still required constant work from the ESs and could not operate without the active involvement and encouragement of the IPS team.

‘We know there is a barrier to referrals with TSKs so we persist. If TSKs won’t tell clients about IPS, the ES will be proactive and go into waiting rooms and speak to people and explain the service and the trial (including randomisation). But it is an ongoing challenge and will remain that way over the course of the trial.’ (ES 11)

In doing so, interviewees identified a number of strategies that ESs used and developed throughout the trial to encourage keyworkers to make referrals.

**Maintaining good informal channels of communication between keyworkers and ES.** Many interviewees reported that ESs took the time to explain the trial and IPS to keyworkers, they kept keyworkers updated on developments and answered their questions about the trial; they reminded treatment staff to refer to the trial in conversations with their clients, and praised keyworkers for referring clients to the trial. All of this helped referrals as keyworkers understood more about the trial, felt like they were involved, and developed trust in the ES as colleagues. Several barriers discussed above relate to some keyworkers not having enough or sufficient information and were often addressed or avoided through effective communication from ESs.

‘With other services, they’re trying to deliver others’ message and that doesn’t work. But in our TS we invest time in explaining everything and we ask them about their frustrations and their worries.’ (TSM 2)

‘The IPS worker at our hub has told me every step of the way what has gone on with a particular client I have referred. She was telling me what she was doing with the client and where they were at. This client was quite successful and has got a job.’ (TSK 6)

**Attending treatment team meetings.** In all waves, across most trial sites and stakeholder groups, ES attendance at team meetings of treatment staff was considered important in encouraging referrals. In these meetings, ESs gave updates on referrals, job outcomes, other good news and generally reminded keyworkers to refer.

One ES reported that they used this as an opportunity to thank and praise keyworkers when sharing news about good outcomes for their clients, while another ES coached keyworkers during these meetings on how to have conversations about employment and the trial with clients.

Another ES used the meetings to share his own experience of how he had changed his mind about employment. He gave an example of a previous client with a mental health condition to be a factor that would prevent the client from accessing employment, who was now working.

Direct feedback from service users had also helped. Two interviewees reported that a presentation given by a client about their IPS experience had been ‘inspiring’ and had led to an immediate increase in referrals from keyworkers following the talk.
Sharing good news stories. In all waves, many ESs used good news stories to show TSKs how IPS can work and how it can work for clients who they did not think could work. This included feedback and results shared formally through team meetings; informally through conversations, in quotes from IPS clients who found work that were put up on a noticeboard in the treatment services’ waiting room, and in the production of a case studies booklet. As well as ‘good news’, one site reported that they had also told keyworkers about cases where clients had been less successful in finding suitable employment but were still being supported by IPS, in order to demonstrate the ongoing nature of the support that clients were receiving.

'To be fair, some of the results have been a bit surprising and it shows that we can't always predict who will be able to get a job.' (TSM 12)

'I work in an office where if you have a good news story, you can put the phone down and kind of shout it across the room and proclaim it to everyone.' (ES 11)

Gaining the support of and active encouragement from treatment services management. Many interviewees, particularly in Wave 3, mentioned that having the support and active involvement of managers from both IPS and the treatment services side was important in encouraging referrals. In some cases, TSMs would work individually with keyworkers who were referring fewer clients to IPS in order to encourage them to make referrals. Other managers might discuss referrals to IPS in keyworkers’ supervisions and in management discussions, told keyworkers about the developments in the trial, explained the rationale behind continued referrals, or talked through keyworkers’ concerns with them. These interviewees felt that having informed keyworkers who understood the reason for the service and the trial was vital to the success of the trial.

'The TSMs initially spent a lot of time getting their head around the trial to understand it enough to discuss with TSKs. The ES spent long time gaining an understanding of TS as well. It’s that understanding that means when you go to meetings, you’re not fighting each other, and you understand what is negotiable and what is not.' (TSM 2)

Other key strategies for encouraging and facilitating keyworkers’ referrals at different points in the trial included:

- **Changing the service initial assessment process to include IPS-AD as an option in the first assessment form rather than waiting until after the full assessment meeting with a keyworker.** This allowed the client to be introduced to IPS-AD at their first interaction with the treatment services rather than waiting for the keyworker to introduce it. Other similar changes included using the IT system to prompt a question about employment for clients upon their three-month review, including employability questions in all treatment plans as a matter of course, and setting joint appointments for the ES, keyworker and client through the case management system.

- **Combing through client lists to find individuals who had not yet been referred.**

- **Reminding keyworkers about the purpose of the trial as something that could then lead to the IPS service being open for all clients.**

- **Setting up shadowing between keyworkers and ESs of their respective casework.** This showed keyworkers how the ES worked with clients and alleviated
some concerns about IPS not being suitable for their clients.  
• Setting up a reward-based system for keyworkers with the highest referrals.  
• Having a visit by PHE to keyworkers to explain the principle that IPS is open to any client rather than clients who are considered to be ready for work.

As explored more fully in section 4.1.6, the Derbyshire IPS-AD service received support from a clinical psychologist regarding how to best engage with clients. While reportedly not the main focus of the collaboration, a few interviewees from Derbyshire reported that this support also gave them some tips on how best to engage with keyworkers in order to increase referrals. While considered useful, ESs felt that this had provided confirmation that the approaches they were already using were working well.

While much discussion in interviews focused on strategies and methods to engage keyworkers in referring, some interviewees mentioned that engaging with clients directly had worked well to increase referrals. Strategies discussed in Wave 2 and 3 included:

• Putting posters up in waiting rooms, publicising positive quotes about work on posters or boards, and sharing leaflets about the trial in common areas.
• ESs talking to clients directly, including by ‘hanging around’ in waiting rooms, common areas or at the entrance, wearing ‘ask me about employment’ badges and engaging with service-user representative groups.
• Attending group sessions to publicise the trial. One TSK explained that they had invited the ES to a group session with clients while one ES from another site explained that they had received a large number of referrals through this route.

• Various information activities. In Derbyshire, for example, one interviewee reported putting together a set of FAQs about how work affected benefits and engaging with a local housing organisation following feedback from service users that these were common concerns.
• Word of mouth. One ES recalled hearing that several clients had volunteered for the trial because they had been talking to another client who was already receiving IPS support and felt it was helping:

’Peer to peer is a good way to spread the word. If you do a good job with someone it will encourage others, it’s really important that you don’t do a bad job.’ (ES 15)

• One site reported running an open session on IPS for treatment service users who were eligible for the trial but had not enrolled, which had a very low uptake.

’Each keyworker will have a caseload of clients and having the IPS on site and visible, and having the promotion of it in the client’s areas, so all the client had to do was mention to the keyworker, ‘Can I be referred to the IPS?’ and it would be done straight away.’ (TSM 13)

Enabling factors that helped encourage referrals included having simple processes and having the IPS team co-located with the treatment services teams. As well as the previously presented deliberate strategies, some interviewees described a few factors that, when in place, were felt to make referrals easier.

An important element of IPS is the co-location and integration of the IPS service with the treatment services (see section 4.6.2). Many interviewees from across sites in Wave 3 also reported that the co-location of the ES with treatment services teams was a key enabling
factor that had driven referrals throughout the trial.\textsuperscript{213} Being in the same building meant that ESs could easily talk to treatment services colleagues about clients and answer questions about referrals;\textsuperscript{214} remind people to refer;\textsuperscript{215} build personal relationships and increase trust;\textsuperscript{216} see interested clients on the same day;\textsuperscript{217} and do ‘warm handovers’.\textsuperscript{218} In addition to being explicitly mentioned by these interviewees, it is clear that a number of the strategies that the ES undertook to build referrals and overcome barriers (such as attending team meetings, having managers work closely between the teams, and talking to treatment services about clients) were only possible or greatly facilitated by this co-location. In this respect, co-location acts as a necessary pre-condition of successful referrals.

‘[ES have] become not just the ES but the person who sits next to someone. I think it’s been the people skills of the ES that have created those relationships and made the referral process and the questioning processes quite straightforward.’ (SES 4)

‘This has been one of the biggest successes of the trial, I’ve been bowled over at how these relationships really, really work and there is some really good working and professional friendships going on. That’s what helps: if a TSK can chat to an ES who is just on the other side of the room, in the same office, that’s really helpful.’ (TSM 2)

‘Their attitude has changed because they see results! They don’t see us as a service that we come in and meet clients and they will see us in 2 weeks again. We are here every day, we are part of the team, their struggles are our struggles so I think that when they see the results they are coming from hard work and they know that they can trust me or my colleagues to take that client on and obviously if they get the IPS they get the best treatment that they can. They see the results for themselves every day.’ (SES 14)

As discussed in section 4.1.1, due to specific geographical contexts, a number of sites experienced challenges in ensuring that physical co-location was possible.\textsuperscript{219} In one site, the interviewee explained that this barrier was overcome by hard work and flexibility of the ES.\textsuperscript{220} In other sites, the barrier either remained or had been overcome by the re-organisation of the service that had moved ESs from working in a central office to being based in new local hubs. In the new local hubs, the ES was co-located with their referring team, which meant that they could attend the multi-disciplinary team meetings and speak with referrers.\textsuperscript{222} ‘We didn’t know the [referring TSKs] and they were often not in the office, they were in the community or doctors surgeries, we tended not to engage with them...It was much more difficult at the start because we weren’t together in one place and our contact with some staff was only by email.’ (ES 15)

Some interviewees reported that the IPS-AD referral form and processes were straightforward and that this made referrals simpler.\textsuperscript{223} These procedures were often felt to be so simple because they were embedded in the same case management system accessible to the clinical teams and ES due to integration.\textsuperscript{224} In one site, one interviewee reported that ES took on the majority of referral work to avoid burdening keyworkers.\textsuperscript{225} A few TSKs felt that having keyworkers who were knowledgeable about IPS, understood why it had been introduced, and believed in the role of employment in recovery was a key facilitator for achieving referrals.\textsuperscript{226} Some interviewees felt that they had spent significant
time explaining the model and the rationale for the trial to keyworkers before the IPS service launched, and that this formed a good basis for referrals and encouraged further openness and a culture of mutual understanding as the trial went on.\textsuperscript{227}

When this shared understanding was lacking, this could lead to challenges in referrals. For example, in two sites, specific misunderstandings such as which organisation ran the IPS services\textsuperscript{228} and confusion about when to refer to IPS and when to refer to other employment services\textsuperscript{229} led to problems in referrals. In all cases, these barriers were addressed by ESs who took the time to engage with keyworkers and explain the nature of the trial and the processes to be followed.

### 4.1.6. Client disengagement with IPS was a continual challenge throughout the trial

Securing engagement from clients of alcohol and drug dependence treatment services is known to be difficult and drop-out from treatment varies depending on type of treatment (between 17\% to 68\%)\textsuperscript{230} and time of measurement (between 19\% and 91\%).\textsuperscript{231} Unsurprisingly, throughout the trial, many interviewees reported having high numbers of clients who did not attend (DNA) scheduled meetings or who did not engage with ESs.

In Wave 1, only a few ESs in two sites reported that this was a problem.\textsuperscript{232} In Wave 2 and 3, however, many interviewees from some sites suggested that disengagement rates had increased. They cited high proportions of the clients enrolled on the trial not engaging with ESs, acting as a significant barrier to successful implementation of IPS.\textsuperscript{233} In Wave 2 interviews, two ESs indicated that the DNA rate for their service was around a third of all clients on caseloads.\textsuperscript{234} There is some evidence that this worsened over time. In a Wave 3 interview, one interviewee from Derbyshire reported that only 48 of the 133 clients enrolled were on active caseloads, and that fewer than half of these actively engaged with the ES.\textsuperscript{235} While in Birmingham, at the same time, one interviewee reported that only half of the clients on caseloads were engaging.\textsuperscript{236}

‘Once they’re on the trial, you can’t get hold of them. You send them texts, letters, phone calls, try to meet up with them when they come to the pharmacist.’ (ES 16)

No clear reasons emerged as to why clients were not engaging with the service

In the IPS model, ESs practise assertive engagement and outreach where clients are not removed from caseloads when appointments are missed but rather make attempts to contact the client using various contact methods and liaising with clinical team members.\textsuperscript{237} Similarly, in IPS-AD, ESs reached out to any clients on the IPS caseload who had disengaged, with the support of the treatment team, and made attempts to reinstate contact and rearrange planned meetings to discuss job search activities.

One COM and a few ESs considered that low engagement was frequently the result of unsuitable referrals, where clients were not, in fact, interested in employment but had simply acquiesced to please their keyworkers.\textsuperscript{238} Others reported that clients’ chaotic lives and alcohol and drug dependence meant that their levels of motivation and interest in engaging fluctuated greatly\textsuperscript{239} and that they did not always have reliable phone access,\textsuperscript{240} which made engagement with the treatment services and IPS naturally volatile. In some cases, clients reportedly explained that they had dropped out because it was the ‘wrong time for them’\textsuperscript{241} or because of other challenges that they felt they had to overcome before being able to address employment issues.

As explored further in section 4.7.3, some ESs felt that clients who were at a further point
in their recovery journey were more likely to engage consistently than others, while others felt that there was no one defining point in a recovery journey at which someone was likely to engage or disengage.

‘I genuinely find it difficult to put a finger on whether, if I have an appointment with someone, whether they will turn up the next time. I’ve had a number of clients who I had a really good first meeting with and then they never turn up again. Conversely, there are some clients who don’t seem enthusiastic but who then turn up and make progress.’ (ES 17)

One SES emphasised that there were likely multiple (and very individual) reasons why clients did not engage, and that this multiplicity of reasons meant that addressing the problem was very difficult. 242

ESs have used a number of strategies in an attempt to tackle low engagement rates, drawing on both the IPS model and other innovative approaches.

Considerable effort had gone into trying to address engagement throughout the trial, with ES using strategies set out in the IPS model and trialling other approaches.

ESs used a number of strategies in line with what is recommended in the IPS model. These included reaching out to clients by text, letter and phone243 and offering to meet clients wherever they were comfortable to encourage their engagement,244 with one site reportedly trying home visits.245 Working alongside treatment services staff was also a frequently mentioned strategy, with many ESs reporting that they tried to secure meetings with clients when they came to pick up scripts246 or when they came to the treatment centres to see their keyworkers.247 One ES also found it helpful to work closely with keyworkers to better understand other ongoing challenges (such as mental health problems) or recent events in clients’ lives, in order to encourage re-engagement at a suitable moment.248

Some IPS services also reported trialling other methods to promote engagement. Two sites organised events which aimed to engage a number of disengaged clients by inviting them to come to a session with an ES and combining this with lunch or nibbles but had had little success.249 In order to ensure that clients who enrolled into the service were interested in employment, one site reported working more closely with keyworkers when first introducing the trial to clients and asking clients more questions upon an initial meeting in order to get a better sense of a client’s interest upon referral.250

One site (Derbyshire) worked with a clinical psychologist during the trial to apply psychologically-informed behaviour change approaches to address non-attendance rates.251 Further information about the nature of this support can be found in Box 2. ESs reported that, as a result of this collaboration, they adapted the language used in letters and texts sent to disengaged clients and in the communication of good news stories to ensure that this was as encouraging as possible.252
Box 2: Addressing non-attendance rates in Derbyshire

The Derbyshire IPS-AD service worked with a clinical psychologist for six months during the trial to apply psychologically-informed behaviour change approaches to address non-attendance rates. At the outset, the behavioural target was identified as client attendance at appointments and an initial formulation of non-attendance behaviour was co-developed between the clinical psychologist and the team. This included, for example, a consideration of the impact that clients’ anxiety around changes to benefits and previous experiences of rejection could have on attendance. Following this, a range of intervention strategies were then selected, with consideration of factors such as acceptability and feasibility. These resulted in interventions co-designed by the clinical psychologist and the ES that drew on evidence-informed behaviour change approaches and included tweaks to flyers, texts and invitation letters, a prompting email to partners, and an amended reminder system.

To check for unintended consequences of this work, the team held an early review of the non-attendance data soon after beginning the interventions. Following this, there was a detailed review session to share learning and to set some further goals for service developments, drawing on learning so far. This found that over the 6 months of collaboration between the clinical psychologist and the Derbyshire IPS-AD team, non-attendance rates dropped from 59% to 34%.

Derbyshire ES presented their learning from this collaboration in an IPS-AD away day workshop, which was designed to enable other IPS-AD teams around the country to think about their non-attendance in psychological and behavioural terms, and to begin the development of interventions tailored for their context.

SOURCE: Information provided by site in Derbyshire.

Having used these strategies, a few ESs reported that they felt that they had done all that they could to engage clients and that there was a point at which clients themselves had to want to be engaged.253 These ES felt that it was important to understand the context and recognise the limitations to what ES could do. While recognising the importance of assertive outreach in the IPS model, one also felt that giving people space was important to ensure that future relationships were not damaged and advocated personalised rather than blanket approaches to attempts to engage clients.

253 ‘If they wanted to come, they’d come, regardless of what you’re offering.’ (ES 4)

254 ‘I’ve got a client who I’ve failed to engage consistently because she’s been worried about her (relative). And things like that. Instead of saying, I’ll take her off the caseload (she’s discharged from services for not engaging), I’ve kept working with her. She disengaged over Christmas because she couldn’t see her (relative). When I called her, she said she couldn’t think about work at the moment. I decided to wait a bit and contact her in early January – and then late January, and she was ready then, she wanted to get out of the house. She’s now finally engaged after not engaging.’ (ES 19)
4.2. Day-to-day activities involved in delivering the IPS service

Box 3: Summary findings to EQ2 (what day-to-day activities did the IPS service involve for participants and staff?)

- The activities which ESs undertook with clients follow the pattern described in the IPS fidelity scale
  - The job-seeking process followed a pattern of vocational profiling, completing a CV and applying for jobs
- In-work support was sometimes challenging or limited because the majority of clients were reluctant to disclose their substance use history
  - Clients were reluctant to disclose their treatment status to employers
  - When ESs did provide in-work support, it involved supporting the clients in a variety of ways
  - Clients reported different feelings about whether in-work support would help them
- ESs also supported and signposted clients to further support at the end of their time-allocated support
- Having a strong working relationship between clients and ESs is key to delivering IPS support
- Employer engagement was an evolving journey for most ESs
  - Over time, good practice has emerged around employer engagement but ESs struggled with some aspects, such as job carving
  - There were some ongoing challenges in terms of employer engagement including employers’ reluctance to engage and clients’ unwillingness to disclose
  - Strategies to address barriers, such as rebranding and changing the language used with employers, were used throughout the trial.

4.2.1. The activities which ESs undertook with clients follow the pattern described in the IPS fidelity scale, although affected by the challenges experienced in engaging clients

Within IPS, there are typically six phases of activity and support. These include: encouraging referrals, initial meeting, vocational profiling (assessing clients’ strengths and weaknesses, preferences and needs), job-seeking, job start and follow-on support. During the vocational profiling process, the ES also offers advice about in-work welfare benefits in preparation for a move into paid work, whether the history of treatment and related health or support needs will be discussed with prospective employers (managing personal information), as well as how much and by what means in-work support will be offered once employment has been gained.

As outlined in section 4.1.6, ESs experienced some challenges when working with clients. These included: difficulties in getting in touch with clients, some of whom do not have phones or who live chaotic lifestyles; clients’ fluctuating levels of concentration, which was often related to a result of their alcohol and drug dependence; and clients’ changeable motivation levels. As external factors affect the attitudes of the clients, their motivation can be high or low at their appointments. The need to motivate clients when they are at their
low points and provide constructive support throughout was recognised as a challenge by one ES.²⁵⁹

The job-seeking process followed a pattern of vocational profiling, completing a CV and applying for jobs.

In the first wave of interviews, ESs explained that the initial meeting was usually in a setting familiar to the clients (the treatment centre), but emphasised that ESs were flexible in terms of where the appointment is set up and that convenience to the client is their priority. This might include meeting a client at a café, a client’s house to accommodate mobility issues, a neighbouring town where many service users live, or a local community centre.²⁶⁰

Many ESs interviewed in Wave 1 mentioned vocational profiling as their basis for developing a good understanding of clients’ needs and aspirations, and to create a full profile of each client.²⁶¹ The main aspects of a vocational profile include:²⁶²

- Benefits, housing and financial situation
- Hopes for, and interest in, employment
- Strengths and barriers in relation to employment objectives
- Support expected in developing skills related to job search or specific job opportunities
- Expectations of conditions of employment (salary levels, location, settings, preferences)
- Employment, education and training history
- Current circumstances and daily routine
- Support networks
- Health and alcohol and drug dependence.

While such an assessment was rarely concluded during one appointment (usually it takes up to four sessions), it was a common framework used by all sites to identify priorities for working with each client during the following two or three weeks.

Information from interviews conducted in Wave 1 indicates that ESs followed what is considered good fidelity in IPS when putting together the vocational profile. Many interviewees explained that vocational profiling did not follow a specific order and depended on the different needs and expectations of clients.²⁶³ Profiling was regularly conducted in the form of a conversation (rather than form filling). This enabled ESs to help clients talk about themselves, and thereby got to know more about them.²⁶⁴ In IPS, turning the assessment into a friendly chat (that is often client-led) helps clients speak about their expectations and what they enjoy. This has a dual purpose: to start building a relationship between the client and the ES, and to tease out features that would make a job a good match for a client.

While there is no fixed structure to such a conversation, ESs explained that initial meetings with clients usually started with some practicalities (for example, about the best ways to reach a client), moved on to vocational aspects, and usually ended with setting up a next appointment and first small action points given to the client, such as providing missing details, and bringing a CV if they have one.²⁶⁵ In IPS, the first appointment usually takes longer than subsequent meetings and it can last from one to two hours.

After the initial appointment, clients met regularly with their ES for one-to-one discussions of progress, demonstrating another key IPS principle that support is personalised and individual. Appointments usually lasted about an hour and some ESs aimed to introduce a routine by keeping the same day and time for future appointments.²⁶⁶ ESs and SESs, however, also emphasised that clients often needed flexibility and that
meetings were held in different locations and more (or less) often than once per week as required. In addition, it was quite common for ESs and clients to check in with each other by text message between face-to-face meetings. For example, the ES sometimes used texts to inform their client of suitable jobs and to schedule a meeting to work on the applications together.

The ESs’ support included updating a client CVs and online job seeking. Clients reported that the ES discussed their aspirations for work, work history and asked the client to bring their CV, if they have one. The ES worked with the client to improve their CV or to create a new one. According to many clients interviewed across many sites and substance groups, the ES helped strengthen the points included in clients’ CVs. The ESs’ expertise in CV construction and their support was appreciated:

‘I’ve not got the best CV in the world so he kind of padded it out for me.’ (IPS client 20, opioids)

Other support provided to clients included help to prepare for an interview, attend an interview, and to access funding to buy clothes for work.

ESs in IPS also provided advice about how their benefits may be affected by earnings (identified as important in the eight principles of IPS). Clients reportedly valued benefits advice since it was important that their income remains stable and sufficient for their housing and daily living needs if income changes with employment.

‘I wouldn’t know how many hours I’m allowed to work either. I discuss these things with [ES]. We evaluate whether it would be worth me going back into work over 20 hours. We’ve come to the conclusion that 15 hours is the best for me because I get to keep my accommodation and I get to keep my ESA.’ (IPS client 21, alcohol)

A TSM described how TSKs spoke to ESs about questions around benefits. Both understood that it can be serious and possibly traumatic for clients to lose their benefits, and finding employment that provides sufficient income for the client’s needs, either combined with benefits or at a level which replaces benefits, was essential in supporting clients’ recovery and wellbeing.

4.2.2. In-work support was sometimes challenging or limited because the majority of clients were reluctant to disclose their substance use history

When ESs did provide in-work support, it involved supporting the clients in a variety of ways

One of the IPS principles is providing time-unlimited support to clients, including during their employment. While time-unlimited support was not possible in the trial setting, ESs were able to offer up to four months of in-work support. Examples of the provision of in-work support were mentioned by several clients.

In-work support in the IPS-AD trial often consisted of reassurance from the ESs that they could support the client with any problems at work that arose. If issues did come up, ES discussed the problems and helped the client decide how to best respond. A few clients receiving IPS support also reported that it was reassuring to know someone would be there to help if the new job fell through or turned out not to be suitable. Another felt that having continued support motivated the client to continue working; IPS acted as ‘a kick up the backside to keep going’. One client described how the ES supported them to tackle a problem where
the client felt their work shifts were too long without a break:

‘I spoke to [ES] who said, “if you don’t speak to them, I will”. So, I thought I should probably do it myself and it went really well when I did. They knew they were taking the mick. If I hadn’t addressed it, I would have ended up leaving. ... So, having the support to talk to them kept me in work.’ (IPS client 22, other drugs)

Beyond problem-solving support, other examples of specific support described in Wave 3 interviews included:

- ESs supporting the client in obtaining all the necessary pre-employment checks which were holding back the client’s start date
- ESs offering general encouragement while the client adjusted to the new routine and began to pay off debts
- Phoning clients on the first few days of a new job to offer encouragement and motivation

Two anonymised case studies put together by PHE and provided by two of the seven alcohol and drug dependence treatment services (Box 4) illustrated two ways in which an ES provided problem-solving support by working with the client, employer and keyworker.
Meeting a client for lunch to provide general encouragement for the afternoon of work ahead

One ES described some good practice of producing a checklist for clients who were in work, which asked them about what they like about being at work and what challenges they have.

Another anonymised case study put together by PHE and provided by one of the seven alcohol and drug dependence treatment services illustrates the support in attending work events and in travelling to work that an ES provided to a client (Box 5).

As is good practice in IPS, one ES started discussing clients’ future in-work support needs with them during the job-seeking process long before job starting works:

“We have adapted in-work support plans, more recently we have been encouraged to plan for in-work support before they have even found a job, so that the client feels supported to go ahead.” (ES 23)

Clients were reluctant to disclose their treatment status to employers

While in-work support did take place, it was often limited due to clients’ reluctance to disclose their treatment for alcohol and drug dependence to employers. In Wave 2, reluctance to disclose acted as a common barrier towards ESs’ ability to carry out much in-work support across sites because ESs were not able to offer support to both client and employer if the employer was not aware of clients’ substance use. As reported by ESs and clients, very few clients wanted to disclose their substance use history to an employer because they feared this would prevent them from getting a job.

“I don’t think an employer would ask about alcohol and, if they don’t ask, I won’t say.” (IPS client 24, alcohol)

“I’d like to obviously not mention that. It’s like putting your age on the CV. They get a picture in their mind about you, then decide “no I don’t want them”. That’s what I think would happen.” (IPS client 25, opioids)

Box 5: Anonymised case study: an ES could provide specific in-work support to address a client’s individuals needs

OC (IPS client) experienced anxiety, and, as a result, had not used public transport for years. Upon joining the IPS-AD trial, the ES quickly brokered an interview with a local business. With the agreement of OC and the employer, the ES sat in the job interview and, when OC was offered the job, took part in three-way discussion between OC, the ES and the employer about what future in-work support arrangements might look like. The ES and OC identified that the most pressing in-work support need was to help OC manage the journey to work on public transport: despite living in the area for several years, OC had never been to the neighbouring town where the new job was based. The ES accompanied her to work every day for three weeks while OC became more confident in making the journey. Once OC became more confident, she required less support from the ES, although they maintained lighter-touch contact, with the ES stepping up support where helpful. One example of this was at a company away day – an entirely new experience for OC, which the ES also attended in a supportive capacity.

SOURCE: PHE and trial sites
Particularly in Wave 3, a few clients reported that they had chosen to disclose their previous substance use to employers. Reasons for disclosing given by clients from the alcohol group were that clients felt it would be better to be open about it and some clients were interested in using their lived experience to work in recovery support.

Even in Wave 3, however, the proportion of clients who had disclosed to an employer remained small. At two sites, ESs reported that only one or two of their clients had been willing to disclose their substance use and treatment status.

‘Out of 97 people in the intervention arm only 2 have disclosed that they are in treatment, and that was because they knew that the employer had disclosed that he had been in treatment himself.’ (ES 26)

Of clients who reported receiving in-work support, only one reported that they had agreed to disclose their substance use and treatment history to the employer and were happy for their ES to be in contact with the employer. The other individuals were supported ‘behind-the-scenes’ by the ES, who did not contact their employer on their behalf. One SES, however, said that employers do appreciate having the support of the ES in situations where the client agrees to this disclosure.

Clients reported different feelings about whether in-work support would help them. Some clients (mainly from the IPS group) described their hope that they could have someone to talk to regarding anxieties when starting a new job. Some clients receiving IPS support concluded that it would be useful to keep in contact with their ES, because they had a good relationship with them and could ask them if they had any problems or queries about their new job or employer. These clients viewed the ES’ role as a helpful safety net, which they would not necessarily need and did not want to be too reliant on once in work.

Other clients, however, interviewed in Wave 3, reported that they did not think that they would need in-work support. The majority of these clients were TAU trial participants who did not have any experience of what IPS could offer. One clarified this with:

‘Providing I was still engaging with [treatment services] and picking up my prescription then the normal support I would be offered would be enough.’ (TAU client 27, opioids)

One ES commented that if in-work support wasn’t provided, in any form, that was primarily because it wasn’t needed:

‘Most of my clients have refused in work support, there is a light touch where I will text them and they text back. When they are off drugs and alcohol, they want to be left alone to do it on their own, they are happy with just a light touch.’ (ES 15)

Another ES reported that the type and frequency of support that clients would find helpful may need to be tested out by their ES once a client started work:

‘If a client doesn’t need you, you don’t need to keep persisting. But if a client does need you, you have to make your presence known so they know you’re still around if they need you – maybe a text every couple of weeks or saying hello when they come in for TSK appointment.’ (ES 11)

**4.2.3. ESs also supported and signposted clients at the end of their time-allocated support**

Due to time-limited IPS being trialled, clients stopped receiving IPS support after a period of nine months of job-seeking or four months after employment had started. Interviews in Wave 3 explored how IPS clients were
supported when they came to the end of their time-allocated support.

Several ESs reported that they planned carefully for the end of clients’ support, which often included:

- Looking for an opportunity to refer to another service for further support for the client.

- Ensuring that clients have the tools needed to continue job searching, including an up-to-date CV and a working email address.

- Sending letters to the clients to remind them that their time accessing IPS support was coming to an end.

- Working with the treatment worker to ‘handover’ some of the work they had been doing with a client, especially when the client’s health problems had been a factor in them not managing to find work.

'I like those letters to be quite personalised, to say something like “If you’re still interested in warehouse work, we now have an opportunity with [other local service].”’ (ES 28)

A few ESs reported that alerting clients to the upcoming end of their IPS support motivated clients to become more active in their job searching.

Other clients, however, noted their disappointment that their time with IPS was ending before they had found work. Indeed, one ES said that some clients felt that the ES was leaving them just when they were getting started. To counter this, the ES reported that they tried to maintain the client’s self-confidence by reminding them how far they have come and that they have the ability to continue job-seeking without ES support.

4.2.4. Having a strong working relationship between clients and ES was key to delivering IPS support

In the IPS model, ESs aim to build a relationship of trust between them and their individual clients in order to know how to help each individual, how far to encourage them, and how to meet their particular needs. Evidence from interviews suggest that this took place in the IPS-AD sites and that building this relationship takes particular skills and qualities.

ESs reported a number of skills and strategies used to build good relationships with their clients. Some discussed the need to be build a relationship that was both professional and personal.

Some ESs felt it was important to show the clients that they were ‘just another person’, with their own passions, idiosyncrasies, and sometimes relevant life experience. For example, one ES mentioned that they had joined a music group set up by and for the service users at the treatment centre.

Other interviewees felt that an ES’s own life experiences, including experiences of dependence themselves, helped them to build relationships with clients.

Other skills that some interviewees considered important included active listening, being empathetic, non-judgmental, and trying to understand clients’ situations. The ability to hear what the clients have to say, interpret or understand what they need, and respond to this with potential ideas and solutions tailored to clients’ preferences was felt to be an important skill and one of the main strengths of the IPS service. Some ESs noted that it was important to be enthusiastic, positive, motivated (and motivating).

Interviewed ESs emphasised the need to see the good in others and believe in people. In building a relationship with the clients they try to empower them without being patronising, giving them the confidence to go back into the workplace by saying ‘you can do this, there are options out there for you’.
few ESs felt that being mindful of their own and client’s body language was important in their job, especially making eye contact and smiling in order to make their clients feel comfortable.  

ESs also reported that it took skill and experience to maintain a positive relationship with clients. For example, adapting approaches if needed was important:

‘One month a client might not be ready, but the next month they might be. Understanding when to back off and when to come back again is important. Ensuring that, when you’ve backed off, making sure they know where you are. Not always pushing work when it’s not the right time.’  

(ES 11)

Several IPS clients interviewed described reported that they felt their relationship with their ES was supportive. Specific comments include:

‘It’s good. We can have a laugh and joke but also [the ES] is really supportive, but not in a smothering way. He’s there as and when I need him even outside of appointments.’ (IPS client 29, alcohol)

‘[the ES was] like a friend to me, with good rapport.’ (IPS client 30, opioids)

‘Everything was explained clearly but not patronisingly. [The ES] was realistic, she didn’t pretend it would be easy for me to find work.’ (IPS client 31, alcohol)

‘She was “real”. She didn’t pretend. It felt like a personal connection and like she understood me...She was totally non-judgemental about [substance use]. Getting that interview, and feeling like I performed well in the interview, helped my confidence and made me feel back in the game, even though I didn’t get it. I could see myself in the job even though it was a field I hadn’t considered working in in the past, so it’s good to be getting new ideas.’ (IPS client 32, other drugs)

4.2.5. Employer engagement was an evolving journey for most ESs

In the IPS model, ESs carry out employer engagement. This involves developing relationships with potential employers, learning about the employer’s work environment and needs, introducing the IPS programme and how it can help the employer. Ultimately, ESs will help a client successfully apply for a job within the company or work with the employer to develop a particular role for a client (job carving’). Systematic job development through employer engagement is a key IPS principle.

In high fidelity IPS services, ESs are required to make at least six face-to-face employer contacts each week and have dedicated time to engaging with employers.

In the IPS-AD trial, employer engagement was included in the core training commissioned by PHE at the start of the trial. In addition, in response to training needs identified, PHE organised individual site-specific sessions with an IPS expert. These sessions took place between Wave 1 and Wave 2 interviews.

While there was increased confidence over time, ESs reported ongoing challenges in conducting employer engagement

In Wave 1, interviewees reported that employer engagement was just beginning, although some activity was reported across most sites. In Wave 2 and even in Wave 3, several ESs still felt they were still at an early stage in terms of providing employer engagement. As a result, some ESs interviewed in Waves 1 and 2 reflected that conducting employer engagement was generally challenging and that they felt that they had insufficient knowledge of how to do it, even after attending the initial core training sessions commissioned by PHE. As the trial progressed, however,
ESs generally reported becoming more confident in terms of the activities of employment engagement. In Wave 2 interviews, challenges around employer engagement included having a low caseload of clients, meaning the approach to employers with a specific client in mind was limited to relevant employers for clients on the caseload. ESs also reported that it was difficult to approach employers when working with clients who experienced fluctuating motivation and engagement. In addition, a few interviewees struggled in balancing the need to engage with employers while also manage recruitment onto the trial. One ES described employer engagement as 'one of the most frustrating bits of the trial' because of the difficulties in building relationships with some companies who conduct recruitment only online.

Throughout all waves of interviews, ESs reported that, while they had found that their engagement with employers had led to better relationships and discovery of relevant vacancies, the ESs interviewed had not had the opportunity to engage in job carving. The most commonly cited reasons why job carving had been less fruitful than expected were that: clients were not interested in the type of jobs offered by employers they had engaged with, clients decided against applying for or taking up offers of employment, or they had already found work a different way.

An anonymised case study put together by PHE and provided by one of the seven sites illustrates how job carving might be carried out by ESs working with employers who were happy to engage with potential employees from alcohol and drug dependence backgrounds (Box 6).

Throughout all waves, many ESs reported that they encountered employers who demonstrated reluctance to hire people with alcohol and drug dependence, which presented a challenge to their employer engagement. Some employers reportedly believed that such clients would be homeless, unreliable and untrustworthy. A few ESs considered that this stemmed from a lack of

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**Box 6: Anonymised case study: ES might work with employers to develop opportunities for clients within companies**

**Employer X** was a local employer with a small business working in specialist sales who an ES contacted on behalf of an IPS client (TJ) who had relevant experience and specialist skills. While Employer X was happy to meet with TJ, TJ decided against returning to work in this sector, before the meeting could take place. Despite the setback, the ES was keen to maintain the relationship with the employer and visited Employer X to explain the situation. While there, the ES noticed that the employer seemed to be overwhelmed by administrative tasks, meaning that potentially more productive activities were often left waiting. The ES raised this with the employer and suggested that having some administrative support could benefit the business.

Employer X was initially reluctant to discuss and explained that it would not be possible to create a full-time post to provide this support. The ES, however, reassured him that for people in recovery, part-time work is often preferable, and, upon further discussion, Employer X agreed to meet DB (a different IPS-AD client) to discuss this new, carved role. DB was subsequently offered the job and accepted it.

**SOURCE:** PHE and trial sites.
understanding and the stigma of alcohol and drug dependence, and felt that employers were more understanding about mental health conditions.\textsuperscript{324} In some cases, employers reportedly did not engage with ESs again after learning that they were from treatment services.\textsuperscript{325}

'Sometimes I've had follow-up meetings with employers and asked more specific questions about how they work with employees with criminal convictions and employers have realised [we work with this group] and not been particularly favourable at this point. There have been some employers who have been happier with it but they are few and far between.' (ES 17)

Some ESs in Wave 2 reported that smaller, local employers had been easier to engage with because it was easier to make connections with them.\textsuperscript{326} This view was not shared by all: two other ESs felt that, in their areas, very small or family-run companies were less likely to engage because local employers were likely to know and recognise some of the ESs' clients from the local community.\textsuperscript{327}

A few interviewees indicated that employers who had more positive views on working with their clients had their own experiences of alcohol and drug dependence,\textsuperscript{328} wanted to help their local community,\textsuperscript{329} or had experience in supporting people with criminal records in accessing employment.\textsuperscript{330}

No discernible patterns were noted in terms of the sectors of employers engaged with IPS. Several ESs reported engaging with a large range of sectors and industries without noticing much difference between them.\textsuperscript{331} Others had observations about different types of employer: one ES reported that engaging with warehouses could be difficult because several required employees to take and pass drug tests.\textsuperscript{332} Another noted that cafés were often quite likely to engage with ESs,\textsuperscript{333} and another that retail employers were less likely to engage.\textsuperscript{334}

As explored in section 4.2.3, clients receiving IPS support were often unwilling to disclose their alcohol and drug dependence use and/or treatment status to employers. As well as affecting in-work support, this also had an impact on how ESs carried out employer engagement. ESs reported that it was sometimes difficult to engage with employers when they could not be completely open with employers about their role and purpose and could not transparently answer some of employers’ questions.\textsuperscript{335} In particular, ESs in Wave 2 reported that being employed by the treatment services and thus having the names and logos of these services displayed on their IPS promotional material and lanyards presented a particular challenge.\textsuperscript{336}

Various strategies to address these barriers, such as rebranding and changing the language used with employers, were used throughout the trial. While many of these challenges persisted throughout the trial, ESs reported specific strategies implemented to address these specific problems were devised and practiced over time.

When asked to reflect on change over time in the Wave 3 interviews (autumn 2019), some ESs considered that they now tried to do more employer engagement and were more confident about it than they had been previously in the trial.\textsuperscript{337} Particular changes that reflect good practice included: carrying out employer engagement in pairs (rather than individually),\textsuperscript{338} adapting employer engagement to use it in cases where there was only partial disclosure,\textsuperscript{339} and focusing more on approaching employers with a specific client in mind.\textsuperscript{340} Many ESs attributed these changes in their practice to the additional site-specific training commissioned by PHE and delivered
by an IPS expert specifically on employer engagement (see section 4.1.4).

'We've definitely changed a lot in the way we do employer engagement: [it is now] focused, targeted, [we are] doing it together rather than individually. Our area is quite compact, so we can go out in twos and threes which feels more supportive.'

(ES 36)

In Wave 2 and 3, several stakeholders reported that they had stopped wearing lanyards or bringing materials that were overtly associated with substance treatment services and instead marketed themselves by (legitimately) using the 'branding' of one of the partners or associated organisation within the treatment services such as the NHS, the local council or another organisation.

'Having an NHS badge is helpful as it means people listen to you as a person. Your personal approachability is important too: we pitch it as 'employment specialist who works with various people from mental health to eating disorders' rather than substance misuse. Some are interested and prepared to listen and give you time and we tell them that we will come back in a week or so.' (ES 16)

ESs also reported that they had changed how they spoke about clients when approaching employers. Several reported referring more vaguely to clients’ health as a long-term sickness or a health condition or that they emphasised the community nature of the service. Some reported that they tried to place focus on the role of the ES in supporting both the client and the employer in order to move away from discussion of clients’ needs.

'The whole subject is harder to broach with employers than mental health and we have ended up in a bit of a minefield where in the majority of cases we are not saying that we are employed by the local drug and alcohol service, and initially that has been difficult but I think we do it well now. We focus on what we can do for the employer, but you do it knowing that you’re purposefully and wilfully holding some information which would potentially change the nature of the relationship were it to be known. It’s an ethical grey area and seems to be a necessity because the majority [of clients] don’t want employers to know their situation and we have to respect that, and we meet employers who have little or no understanding except the sensationalism that they see in the media.'

(ES 26)

There is, however, a sense that while such strategies may have allowed greater engagement with employers, they were less helpful to facilitate ESs’ ability to carry out in-work support, which remained limited (as explored in section 4.2.2).

Over time, good practice has emerged around employer engagement

ESs reported a number of practices in carrying out employer engagement that they found to be particularly helpful or effective. Many of these follow the recommendations in the IPS model.

ESs reported that dedicating time to employer engagement each week and having a set number of contacts to make (both requirements of high fidelity in the IPS model) were helpful in ensuring that employer engagement took place. One SES mentioned that scheduling time for employer engagement had become more systematic over time in their service: while it used to be a ‘do it if you have time’ activity, the IPS team in that site had found that this tended to slip due to other pressures and had rectified this by adding dedicated time slots to ESs’ diaries.
In terms of getting in touch with employers, conducting desk research before speaking to the employer to find out about their company, their needs and any vacancies was considered good practice, as was following up ‘warm leads’ by approaching employers who were already looking for workers. For example, ESs reported that telephoning employers who had frequent vacancies to ask about open days and attending job fairs were helpful ways of gaining intelligence and getting to know employers. In general, ESs reported that making face to face or phone contact with the employer rather than relying on email only when getting in touch for the first time was also helpful. An anonymised case study put together by PHE and provided by one of the treatment services illustrated how ES might make contact with employers through recruitment fairs and events (Box 7).

ESs also reported that they generally engaged with employers keeping specific clients in mind. Many ESs from all sites in Wave 2 and 3 reported that while they had initially conducted employer engagement in a broad sense, they now approached businesses with a specific client in mind, who they would then aim to introduce to the employer or encourage to apply for a vacancy. A few ESs reported that they no longer did any ‘general engagement’ but only for specific clients because they found that this was more effective.

When talking to employers, ESs often focused on explaining and emphasising the potential benefits the ES could bring to the employer. Explanations often focussed on the potential free recruitment service that ESs could bring to employers by matching vacancies to clients and reducing the employer’s workload in terms of filling vacancies. ESs also asked the employer questions about their recruitment processes and about what the employer looked for or valued in employees. One employer interviewed mentioned that they worked with the ES in the same way as they would with a recruitment agency.

‘They became like our recruitment business. They knitted with us – I needed somebody who does all of that stuff. The ES did the initial matching to our requirements, like a recruitment agency would do. He would send a CV over, and ES helps me with that first interview.’

(EMPL 33)

An anonymised case study produced by PHE and one of the treatment services illustrates how ES might work with employers to fill a difficult vacancy and assuage any concerns about working with the client group (Box 8).
Box 8: Anonymised case study: ES emphasised how they could help address employers’ needs as well as clients’ needs

AV (IPS client) was keen to find work as a maintenance worker or similar, with a preference for physical work and working at night. While they were searching for suitable job opportunities, they spotted a vacancy for a porter at a busy local restaurant. The ES approached the general manager of the restaurant to explain the IPS programme and to broker an opportunity for the manager to meet AV. The manager met AV, who was happy to talk through aspects of their treatment and recovery journey. In turn, the manager was happy to talk to a potential candidate for a vacancy that had been difficult to fill due to the demanding nature of the role and the unsociable hours. The manager reported that while he was a little apprehensive about recruiting someone from treatment, the relationship developed, and the ES had provided the reassurance he had needed. The manager had interviewed other candidates, but was struck by AV’s enthusiasm, and was keen to give them the opportunity to show that they could do the job. After a short paid trial, AV was offered the job. While the work trial was going on, the ES contacted the local council and helped the client access a scheme providing a free bicycle to those starting work, meaning that AV can now get to and from work independently.

SOURCE: PHE and trial sites.

In interviews, ESs also considered that it was important to recognise the limits of what an ES can do in terms of engaging and working with employers. A few ESs emphasised that it was important not to insist too much with employers if they did not seem keen to form a connection with the ES or employ a client to avoid alienating them and damaging potential future relationships and the ability to fill job vacancies. One SES felt that following the common IPS ‘three cups of tea’ strategy with employers was not helpful, as employers were suspicious of ESs’ motivations and did not have the time to spare. Another ES also emphasised the need to avoid doing too much for the client in the job application process, but instead allow them to demonstrate their own capacities to a potential employer.

‘You don’t want to do so much with the employers that they think the client can’t do anything for themselves.’ (ES 34)

While these practices were reported widely, one SES noted that a variety of approaches were necessary and depended on what was considered necessary for specific employers and on the individual preferences of ESs. Not all good practices were used to approach and engage with all employers at the same time.

‘We try to work out what is best for the employers and different things work for different employers.’ (ES 34)
4.3. Participants’ expectations of their opportunities to obtain employment before and after the trial

Box 9: Summary findings to EQ3 (what expectations did participants have of their opportunities to obtain employment before and after the trial?)

- Clients had differing levels of confidence about finding employment
- Some clients reported having a wide range of previous work experience which increased their expectations of finding employment
- Clients reported that their personal situation often lowered their expectations that they could find a job
- Different factors motivated and raised people’s expectations around employment.

4.3.1. Clients reported differing levels of confidence about finding employment

In interviews in Waves 2 and 3, several clients felt that their job prospects were limited, but they appreciated the help of their ES, and in general found it very effective in building their confidence.365

The nature of clients’ expectations and motivations varied. Although some clients reported that they were keen to find a job of any sort so that they could more easily pay for their living costs,366 others had higher aspirations, including permanent work with opportunities for career progression, which would be the foundation of a more stable life.367

Interviewed clients were often confident about their ability to find a job in the short- to mid-term future. When asked how likely they felt it was that they would find a job in the next 3-9 months, several clients (in both the IPS and TAU groups) considered that the likelihood was “above 50%.”368 This included some clients in the control group who were not receiving IPS support, such as one who reported that they were using library services to job search on computers and were confident that they would be employed within 12 months,369 and another who was confident in their own ability to get a job without other support.370

4.3.2. Some clients felt that previous work experience could be helpful in searching for employment increased their expectations of finding employment

Previous experience in work was commonly mentioned as a key factor for whether clients could see themselves in employment in the near future.

In Wave 3, several clients described previous work experience, which they felt could be useful in their search for new employment. Clients reported having a range of previous work experience:

- In factories or warehouses371
- In elementary occupations including as driving, bar work and cleaning372
- In gardening or catering373
- In retail positions374
- In caring positions375
- In a variety of white-collar professions.376

Some clients, however, were not interested in returning to roles in which they had experience, because that experience was now out of date, they no longer enjoyed that work, or needed to move on in life, away from circumstances in which they had been using substances.377
4.3.3. Clients reported that their personal situation often lowered their expectations that they could find a job

In both Wave 2 and 3 interviews, clients from both IPS and TAU groups described similar reasons why they had low expectations about finding employment. Further barriers to employment are explored in section 4.4.

Clients reported that they had low expectations about finding employment because of their personal situation: including specific health problems, reliance on prescriptions and unstable housing conditions.

‘[I’m] very unlikely [to find work] because of my [injury]. I can’t do much walking and I have blackouts.’ (TAU client 35, alcohol)

‘[My] client – he is very motivated to go back into work, but the housing situation is not stable. [He is] keen to engage but he wants to sort out his housing situation first.’ (ES 36)

Clients also reported that their expectations were low because they lacked relevant training for particular positions or the necessary computer skills for office jobs.

‘There’re more obstacles in my way now than there were years ago. Before, I wouldn’t have had trouble getting a job. But now it’s all driving licences, computer skills, years of experience, Level 1 and Level 2.’ (TAU client 37, opioids)

Other clients reported that their anxiety about interacting with new people and the process of starting work again after a long period of unemployment was a reason for their low expectations and motivation to get back into work. One client was worried that employment could lead to relapses.

‘I’m not sure what I want to do. I’m concerned about getting into a job that makes me more stressed and distressed and triggers me relapsing to alcohol.’ (IPS client 32, other drugs)

Several IPS and TAU clients also suggested that possible age discrimination was a barrier to employment and felt that they might not be able to get a job because they were too old. This was mentioned as affecting those over 60 or even over 45.

Beyond personal situations, some TAU clients reported concerns that employers were not interested in employing people they did not already know, which lowered their expectations that they themselves could ‘get a foot in the door’. Another client reported concerns about the economic situation on their ability to get a job.

‘It’s a scary thought isn’t it? I just want to snatch up a job before Brexit comes in.’ (IPS client 25, opioids)

4.3.4. Different factors motivated and raised people’s expectations around employment

Clients interviewed in Wave 2 and 3 gave a variety of reasons why they wanted to work which were similar across substance group, site and IPS and TAU clients. Motivations to work included having greater income and therefore financial independence, enabling a more stable life and allowing clients to have more social contact and to meet more people. Some clients felt that being around people would also be beneficial to their mental health and their recovery from alcohol and drug dependence.

‘I want to find a job because I want a normal lifestyle. When I was younger, I was always working but that went out of the window with the drugs. I’m sick of it. I want to work, pay my bills, go on holiday… The life that I’ve been leading, it’s not a life.’ (TAU client 38, opioids)
'My grandparents worked, and I saw what good lives they had. If I stay on the dole, I’m not going to have half as good lives as they had. I see all my family working and I want a piece of that.’ (TAU client 39, opioids)

'I just wanted to work at a charity and find work to keep me going. It helps with my depression. I wanted to get into work to mix with people.’ (IPS client 40, opioids)

'Because I’m doing nothing, my head has time to sit and think and it doesn’t shut off. If I got out and was occupying it, and meeting new people and doing things, it would make a big difference. Because I’m isolated in my life, I don’t go out. I come to town once a day for my prescription and that’s it.’ (TAU client 37, opioids)

'If you’re physically fit enough to work, you should [meet others], because you’ll go stir crazy with nothing to do.’ (IPS client 41, alcohol)

'I want to get back into work to stop me from drinking. It’s just through boredom that I drink. If I’ve got something to concentrate on, then I can do it.’ (TAU client 42, alcohol)

One of the key motivators to work, mentioned by both IPS and TAU clients and across all substance groups, was to **give back to the community and help others**, particularly people with alcohol and drug dependence issues.  

'Ideally I want to be a drug treatment peer mentor and be a holistic therapist.’ (TAU client 43, alcohol)

'[I’m] not actively looking for work at the moment though employment is my goal. I’d like to help other people with addiction.’ (TAU client 44, other drugs)

'I want to work in substance misuse and homelessness to put my past experiences to positive use.’ (TAU client 45, opioids)

'I used to work in hospitality and bar work. I am now more interested in youth work, being a mentor. I’m passionate about helping younger generations to avoid mistakes I have made.’ (IPS client 46, other drugs)

As explored in more detail in section 4.1.6, a range of interviewees, including IPS and TAU clients, reported that clients often had **low or fluctuating motivation to find work**. An ES reported how challenging it can be to keep clients motivated in the face of rejections and disappointments:

'It's difficult to keep people motivated when things don't go right. They seem to think we have a cupboard full of jobs and can just hand them out sometimes. But getting a job can be difficult. Most people who were motivated enough are in employment now.’ (ES 47)

'Speaking to other SESs, it's a common theme throughout: if you get people [IPS clients] on a good day, then they’re very interested [in looking for work] – but we only get a short amount of time with them, compared to their daily lives. That can knock people and they think that they’d rather not work… after every [IPS] appointment, I get a number of calls/emails and one will say "I don't think I can do it", another will say "I'm really looking forward to it, thank you". It's very much up and down; constantly difficult to deal with compared to other support programmes. But ultimately, it's not just the substance misuse, it's the long-term unemployment too that causes fluctuating motivation and confidence.’ (ES 48)
4.4. Barriers and facilitators associated with finding employment and the extent to which the trial has addressed these

Box 10: Summary findings to EQ4 (what were the barriers and facilitators associated with finding employment and to what extent did the trial address these?)

- Most clients felt that IPS had helped in achieving their employment goals
  - IPS support reportedly helped clients to overcome lack of confidence
  - IPS support reportedly helped clients to overcome fear about losing benefits
  - Some clients reported their alcohol and drug dependence was reduced through looking for and starting work
- Clients, however, reported several perceived and actual barriers to work which IPS did not (and cannot) address
- Clients reported that they appreciated the support they received through IPS
- Clients who did not receive IPS support felt the lack of it
- IPS may have an indirect positive effect on clients’ relationships
- Some clients reported areas where they felt the IPS service they received could be better.

4.4.1. Most clients felt that IPS had helped in achieving their employment goals

IPS support helped clients to overcome lack of confidence

Many interviewed clients reported that IPS was helpful in overcoming a lack of confidence, frequently mentioned as a barrier to employment. Several clients described how working with an ES helped build their confidence and supported them to feel more motivated and more positive. Some other stakeholders (including ESs and keyworkers) also reported that some of their clients’ confidence and motivation had increased because they felt supported by their ES and knew that their ES had confidence and belief in them.

“Helped me engage with other services and use them more positively because I recognise I have more people rooting for me.’ (IPS client 22, other drugs)

‘I was resigned to being on the dole but someone believing in me has made me believe I can. Even if this job doesn’t work out, I’m motivated to look for another.’ (IPS client 50, alcohol)

Two ESs explained how they worked to raise clients’ confidence and tackle this barrier:

‘It is people’s confidence which tends to be the main barrier. The fear that they will not succeed in the workplace or will relapse. I think it’s good to show what others in a similar situation have achieved. Also I like to focus on what they find to be their strengths, like if they have had to use initiative and lots of activity when they were using, they were very industrious, I help them to see how they can use this energy for a more positive outcome.’ (ES 51)
'Rather than just saying "you’re brilliant", it’s drawing that information out and it’s just through experience and using open-ended questions that make the client realise who they are.’ (SES 4)

IPS support helped clients to overcome fear about losing income through benefits

Some interviewees reported that clients’ concerns that working could have a negative impact on their benefits and financial stability was a barrier that acted as disincentive to work. This concern was often connected to unstable housing: clients were also concerned that, by working, they may lose their housing, particularly if they lived in supported accommodation or received housing benefit. As described in the IPS model and in section 4.2.1, providing benefits counselling and advice to counter these concerns was an important aspect of the ES's role in the IPS-AD trial.

For example, one SES commented that such support had not always been provided and emphasised the ways in which the IPS team had attempted to address this perceived barrier through talking to keyworkers and clients:

'I have offered benefits advice in the hope that people can see benefits won’t be negatively affected [by employment], clients will be more likely to want to go into work and so try the IPS trial. One keyworker sat in one of these appointments, and that was a massive eye-opener – that we weren’t going to make people do things to be worse off.’ (SES 4)

"Part-time isn’t an option. I’d lose my Universal Credit so it’s got to be worthwhile." (IPS client 52, alcohol)

'The majority of the clients are non-working and afraid of having to pay extra, worried about whether they’ll keep the roof over their head. Some are in hostels and can’t work because it costs £150 to keep the hostel bed.’ (TSK 53)

Some clients reported their alcohol and drug dependence was reduced through looking for and starting work

In Wave 1 interviews, at the start of the trial, keyworkers and ESs reported that alcohol and drug dependence had impact on clients’ attention span, energy, anxiety and behaviour and represented a significant challenge to clients’ abilities to maintain an everyday routine and success in employment. A few clients noted that their alcohol and drug dependence also posed a barrier to their employment.

'[There are] a lot of barriers [to employment]. Initially their substance misuse. The nature of the problem is their attention focus; energy and the time spend around the dependence.’ (TSK 54)

Some IPS clients in Wave 3 reported that looking for work and starting work had prompted a reduction in their drug use. Some clients felt that this reduction was because they were motivated by the prospect of employment starting soon and prioritising finding a job instead. Others reported that their use had reduced directly as a result of the work they had done with the ES or because they had found employment. Clients explained:

'I've made a big effort to cut it down, haven’t stopped but want to cut it down because I don’t want to go into a full time job and be using drugs habitually. Even on the short term, you feel groggy.' (IPS client 20, opioids)

'Working with [ES] has made me realise that cannabis is not top of my list anymore, it’s still on my list, but it’s gone down a few pegs now and I’m prioritising things a bit better now. I’d like it to come off the list full time, but I’ve got to do baby steps with that.’ (IPS client 46, other drugs)
‘My use dropped significantly when I started the job … I feel more independent now I’m making my own money, because I’ve earnt it myself I should spend it on things for me, and not on dependence.’ (IPS client 56, alcohol)

A few ESs and keyworkers also reported similar changes in their clients which they also attributed to the effects of the IPS support received. A keyworker said:

‘[IPS] has changed their [clients’] outlook on life, helped them escape the trappings of alcohol and drug dependence and given them a new opportunity to have a positive focus … if they’re happy the people around them are happier.’ (TSK 57)

4.4.2. However, clients reported several perceived and actual barriers to work which IPS did not (and cannot) address

Clients in both the IPS and TAU groups reported a number of barriers, which were not always met or able to be met by the IPS model. Many IPS and TAU clients believed that they would struggle to find employment because they did not have the necessary work experience or references for the job they wanted. Other expected challenges included worries about accumulating debt through employment, having a tattoo, which would put employers off or lacking the necessary documentation for some jobs.

Coexisting health conditions were another reason why several IPS and TAU clients thought that they would be unable to find suitable work. Some were concerned about the impact of physical health problems, while others considered that their chances of gaining employment were lower because they have mental health problems, such as anxiety and insomnia. Some clients mentioned their caring responsibilities would not allow them much time for employment, since childcare was difficult to find or too expensive, particularly if a client had more than one child needing care.

Clients and keyworkers across all waves reported some concerns that having a criminal record, especially where the sentence was custodial, might present a challenge to finding employment. Having a criminal record appeared to be of most concern to opioid users (according to keyworkers and clients interviewed), which may be due to the nature of this dependence involving use of class A drugs. To some extent, this was reflected by one employer interviewee who agreed that due to the nature of their sector it would be difficult for them to hire anyone who had a criminal record.

4.4.3. Clients reported that they appreciated the support they received through IPS

Many IPS clients who were interviewed in Wave 3, including clients from every site and substance use group, said they were very happy with the IPS support that they received. Yet, we recognise that the group of clients who volunteered to be interviewed about their IPS support were more likely to be those with a positive view of their experience.

‘I think my ES is amazing – he really listens to me, and it matters that people make the effort to understand me and not put me in a silo; takes a very special person.’ (IPS client 58, opioids)

‘I don’t see how it could work any better. There’s plenty of time been allocated for me. If I send a text message I get a reply the next day. I couldn’t ask for more.’ (IPS client 59, alcohol)

‘[The ES has] come with me to interviews - there are a few when I’ve been anxious, and she physically took me.’ (IPS client 60, opioids)
Specifically, clients appreciated knowing that their ES was available by phone\textsuperscript{419} and enjoyed the flexibility\textsuperscript{420} and the amount\textsuperscript{421} of IPS support that was offered.

As discussed in section 4.4.1, clients were often concerned about the impact that working could have on their financial stability and benefits. For some clients, the IPS support received addressed this barrier: clients reported that they received useful information about how their benefits would be affected by earnings. These clients found this to be reassuring because they could see that working would mean their income would be higher than if they remained on benefits.\textsuperscript{422}

4.4.4. Clients who did not receive IPS support felt the lack of it

Two TAU clients felt they would find it hard to get a job because they had been randomised to the control group\textsuperscript{423} and another felt that the lack of support they received was a barrier that they faced:

‘In an ideal world I’d have a weekly thing where I could sit down with somebody and go through applications and apply to jobs with them. And not allow me to run away at the very least. I don’t know whether there’s anything out there like that.’ (TAU client 61, alcohol)

4.4.5. IPS may have an indirect positive effect on clients’ relationships

Some clients were asked in Wave 2 and 3 interviews if working with an ES had made any difference to their relationships with family and friends. While some clients felt that this had made no difference,\textsuperscript{424} others (especially in the alcohol and other drugs groups) reported improved relationships with family and friends since working with their ES.\textsuperscript{425} Clients felt that this was because their family and friends were happy that the client was trying to find employment\textsuperscript{426} and because the client themselves felt more positive and spending more time with their relatives.\textsuperscript{427}

‘[My family] are happy that I am getting the help to find work.’ (IPS client 62, opioids)

‘[My family/friends] are chuffed for me. Saw an old school friend in April and I was sheepish. Saw her more recently and I was excited about what I’d achieved, and she was pleased for me.’ (IPS client 50, alcohol)

‘I’ve seen more of my family. Because when I am just on drugs, I don’t want to see anyone cos I don’t feel good. I have nothing to contribute, I feel like a waste of space. That’s changed.’ (IPS client 20, opioids)

Clients who have found employment described the positive difference it made to their lives:

‘I’m glad that I’m working – it gives me a reason to get up in the morning and I will have some money at Christmas to buy presents for my kids.’ (TAU client 63, alcohol)

‘My job is going well. I am really enjoying it. I have been told I can stay with the company for 5 seasons.’ (IPS client 64, opioids)

‘Now that if I’m working on a Saturday it boosts me up for days, because I feel like I’m worthwhile – because people do judge you. Finally I feel like things are going right, before there was no light at the end of the tunnel, getting older, and I just thought I need to do, I want to do something with my life, because otherwise if I’d carried on drinking I would have been dead, that would’ve been me gone without doubt.’ (TAU client 65, alcohol)
4.4.6. Some clients reported areas where they felt the IPS service they received could be better

A few clients interviewed in Wave 2 and 3 discussed elements of IPS support that they felt could be improved.

Sometimes this related to managing expectations: one client had hoped for help to improve her computer skills which had not materialised,\(^{428}\) while another was disappointed that they had not found employment as quickly as they believed that the ES had promised.\(^{429}\) Other clients reported that the IPS support they received was not sufficiently long-lasting to be helpful,\(^{430}\) which may relate to the time-limited nature of the IPS delivered in the IPS-AD trial (see section 4.2.3). Despite the efforts made by ES to work in the community, at least one client reported that they had not been able to meet the ES close enough to their home.\(^{431}\)

‘I’d rather the ES would be upfront with you and … not give you false hopes … in November they told me I’m going to be working in a few weeks and now we’re in mid-February.’ (IPS client 66, alcohol)

Others felt that their ES was not very accessible or responsive,\(^{432}\) that the onus was too much on the client to job search rather than the other way around,\(^{433}\) or that the ES had not been helpful in suggesting appropriate jobs that they could apply for.\(^{434}\) One client felt that their ES was less able to help people with autism and other neurodiversities\(^{435}\) and two felt that their ESs did not have enough links to employers\(^{436}\) to be helpful.

‘I do not find the ES very accessible. We meet every month or so, but sometimes he is not available, or he is not on email… he promised things that never materialised. … It would have been nice to get help with shoes or vouchers, but it does not matter to me. But if you promised me suit and boots, then you must deliver on it. But it may be something that slipped off his radar.’ (IPS client 67, other drugs)

This is useful feedback for further implementation. In working hard to establish a relationship of trust, ESs are setting certain levels of expectation of a service which they may not be able to achieve for reasons of resource availability, level of skill and experience or simply luck. Although previous IPS trials have demonstrated that the approach is more effective than alternatives, nevertheless at best it has been shown to work for only about 55%-60% of clients.\(^{437}\) ESs need to communicate a careful balance between fostering the hope of job success and realistic appraisal of what might be possible in the current circumstances given the client’s skills, the ESs’ knowledge and the local job market.
4.5. Participants’ experiences of contact with other local employment support services and how this compared to IPS

Box 11: Summary findings to EQ5 (what were participants’ positive and negative experiences of contact with existing local employment support services?)

- Many clients reported that they did not find the support provided by JCP very helpful
- Most interviewed clients did not receive employment support from treatment keyworkers
- Some clients accessed employment support or training from the voluntary sector, colleges and other organisations
- Clients who received IPS support felt that IPS was more personal, accessible and flexible than support from elsewhere
- Clients in the control group did not receive IPS but were signposted to other employment support as per standard practice.

4.5.1. Many clients reported that they did not find the support provided by JCP very helpful

Our findings show that JCP was the main source of employment support that clients in both the TAU and IPS groups received, both prior to the trial starting and during the trial (especially for TAU clients).

As explored below, many interviewed clients shared negative experiences of previous interactions with JCP. These findings, however, should not be read as an assessment of the support that JCP provides to clients in treatment services, as this was not within the brief of the process evaluation. Rather, we report some of the views gathered during interviews with clients in the IPS and TAU groups who also had experience of receiving JCP support. Their views cannot be considered as representative of all clients with alcohol and drug dependence accessing JCP support. Yet, they illustrate some perceptions and experiences of clients with alcohol and drug dependence.

Some IPS and TAU clients from a few sites did have positive comments about the support they had received from the JCP. Clients reported that the JCP put them on a course that had led to a job offer, that their work coach had helped them to find appropriate jobs and vacancies, and that JCP job fairs and resources were useful. Others were positive about the relationship they had with their work coach, stating that individuals had been flexible and supportive and generally friendly and willing to listen. A few, however, noted that this depended on the individual work coach rather than being reflective of the JCP as a whole.

'I had a good experience at the JCP, [be]cause they had regular up-to-date info about opportunities and avoiding financial difficulty; I had one woman who found me the [...] food bank provision this went well; but it depends on the person you get there – I was lucky.' (IPS client 68, opioids)

'[Work Coaches] take each person as an individual and don't apply a blanket approach – they take whatever is going on in people's life and apply the support that is needed.' (JCP representative 70)

Despite this, many interviewed clients in both Waves 2 and 3, from almost all sites and across all substance groups, were more
negative in their descriptions of the support that they had received from JCP, reporting that this had not been helpful or useful in their job search. Some clients felt that the JCP support that they received was not very detailed or constructive. In particular, some clients reported that the support they received had not gone beyond being required to provide work coaches with a list of jobs they had been looking at, while others reported that they had not received support on specific elements of job-seeking that they had struggled with (such as updating a CV). A few reported that not seeing the same work coach consistently had a negative impact on their ability to form a working relationship, while others reported that they had been refused support by the JCP altogether. The fact that one client felt that the JCP had been ‘very good’ to him because they had not issued any sanctions may highlight just how low clients’ expectations were in relation to JCP’s capacity to support them in searching for employment.

Some clients and stakeholders also felt that JCP work coaches lacked knowledge about the drug and alcohol treatment services and the process of recovery which made the employment support that they could provide less helpful. As noted in Wave 1 interviews with JCP workers, work coaches were not specialist in this area and this could lead to difficulties in identifying clients with substance dependencies and therefore in supporting them adequately. There was, however, some suggestion that this understanding may have grown over time: two JCP representatives interviewed in Wave 3 felt that JCP had deepened their understanding of clients’ needs and tried to improve their accessibility and reduce clients’ mistrust.

‘They just tell you to go away and do it on your own. I weren’t (sic) very good at doing it on my own. I didn’t have the confidence... It was too easy just to write anything down in your book without doing it. They didn’t have a clue whether you’d done it or not.’ (IPS client 71, opioids)

‘I tend to get passed around a lot. It’s hard to get comfortable and build up a rapport to start talking to them.’ (TAU client 61, alcohol)

‘I’ve got no Work Coach at the JCP. I’ve had no support from them at all ... I’ve had to go down there so many times to sort things out. I’ve never seen the same person twice there.’ (TAU client 61, opioids)

Regardless of this, some clients reported that they felt misunderstood and anxious after interactions with JCP because of this perceived lack of understanding about recovery. ‘The JCP aren’t helpful. They don’t understand recovery. They think, once you’re detoxed, that’s it - but it’s the bit after that’s the hard part. There’s not
one person at the JCP who understands addiction.’ (TAU client 74, alcohol)

‘I struggle with my energy levels and want to get off the [medication for dependence], but I have tried before and I know I will have six months of insomnia – and that the JCP will see me as recovered and have no reason to maintain (my) benefits, at the same time as going through all those withdrawal effects.’ (IPS client 68, opioids)

Indeed, several clients interviewed demonstrated considerable mistrust of and dislike towards the JCP. Some reported that they felt that JCP work coaches were not always motivated to help clients succeed and that they were more interested in monitoring clients than helping them with their problems. Others felt that the JCP prioritised getting people into work without taking clients’ other commitments or preferences into account. As a result, some clients reported feeling ‘pushed into’ applying for jobs which they felt were unsuitable due to their health or caring commitments.

4.5.2. Most interviewed clients did not receive employment support from their treatment keyworkers

Many clients interviewed in Waves 2 and 3 (from several sites, IPS and TAU groups and all drug groups) reported that they had not received any employment-related support from their drug and alcohol treatment workers. This was reported most frequently by interviewees from Birmingham, Blackpool and Brighton & Hove, but was reflected across all sites. One commissioner suggested, in interview, that this is likely because TSKs were focused on other aspects of supporting clients through recovery and did not have time to focus on employment.

‘They are totally focused on the day-to-day clinical management, particularly in the drug service. It is not that they don’t recognise that work is part of the recovery, it is just because they don’t have the capacity and time to work coaching into employment.’ (COM 78)

A few clients, however, from different sites and mainly from the alcohol group, mentioned receiving some intermittent and informal support from TSKs with employment-related issues. A few clients in the control group reported that keyworkers had given them information about training courses in order to help them find employment. One client described more extensive support. Their keyworker had helped them with their CV, referred them to a computer course to help them gain relevant experience, discussed
employment with them and helped them put their CV forward for jobs. While the client in question had not found a job at the time of speaking, they reported that this support had helped them feel more confident to apply to other jobs. Some clients reported working with another (non-IPS) employment support worker at the treatment service who helped them with job searches and improving their CV and others in Birmingham had received general information on where to apply for jobs and which courses were available at local colleges in a recovery course.

‘[I spoke to] a keyworker a few times about wanting to go to college to do an animal care course. She got me the college course books.’ (IPS client 71, opioids)

4.5.3. Some clients accessed employment support or training from charities, colleges and other organisations

Some IPS and TAU clients in Wave 2 and 3 also reported that they had received job-seeking support from other organisations, although most examples were given in Wave 3. It is worth noting that sometimes ESs also liaised with other support-giving organisations to provide additional support for their clients when appropriate. This is explored separately in section 4.6.4.

Clients most frequently referenced support from the voluntary sector in terms of job-seeking support outside of the JCP and IPS. In general, this support was found to be helpful. This included a number of charities that provide support with developing work readiness and applying for jobs. The reasons why clients found these supports helpful was because they were made to feel trusted and not overly monitored, because of the one-to-one support, and because of the large number of contacts with employers. In summary, these clients valued the one-to-one support from voluntary sector organisations and opportunities to find work in a non-pressurised way. One client who received support from one of these charities reported that while the charity had more contacts and funding than IPS did, ‘it was more personal’ working with their ES.

‘[The support received was not] the stereotype where [the charity worker] is in your face, breathing down your neck. The worker is cool.’ (IPS client 29, alcohol)

‘I liked that someone could help me because I … feel that I am missed out … The one-on-one format is good and I felt that I could be myself.’ (TAU client 80, alcohol)

‘If you’ve been out of the game for a while it can be really positive having that help. I get help tailoring my CV and showing that I really want to work.’ (TAU client 81, opioids)

Other sources of help were accessed from training and recruitment agencies and experiences in this area were generally positive. Such support was considered helpful for clients in the control group helpful because such companies had many links to employers, because workers demonstrated their confidence in clients and because of the personalised and tailored support the client had experienced. Another client receiving IPS support, however, felt that the support they received from employment support providers was less positive than the IPS support because workers did not care about individual’s job outcomes.

‘I just decided to push myself, I bit the bullet … I didn’t think I was capable of doing the shift [at a café] … it made me panic, … it was a new job, something I’d never done before, but I didn’t over think it. I just said yes I would do it … They had confidence in me. And it was fantastic, it brought me out of my shell and I decided
it was the road I wanted to go down. They offered me vocational courses so now I have the certificates I need ... my children were really pleased for me.' (TAU client 65, alcohol)

'They are quite good, you get personal support, and I was passed on to them from the drug treatment centre, so they knew a bit about my background...They help with your CV and finding suitable courses and jobs.' (TAU client 82, alcohol)

A few clients mentioned other avenues of support:

- Some clients received support from local colleges, in terms of undertaking a college course, receiving free haircuts and nail therapy and attending courses about dependence and crime. While one client reported being disappointed by their course being cancelled, others did not offer an opinion on how useful the courses were.

- One client received mentorship and assistance from a local chamber of commerce to set up their own business.

- One client had support from a group that aimed to get people into work through promoting recovery through time in nature.

- One client referenced support from their probation officer, which was considered helpful.

4.5.4. Clients who received IPS support felt that IPS was more personal, accessible and flexible than support from elsewhere

In Wave 1, there was very little data relating to the clients’ experience of IPS so far, largely as the perspective of clients themselves had not yet been gathered. Initial views, however, from treatment services staff on whether or not IPS made a difference for their clients was often positive. Keyworkers highlighted how ESs had been able to work successfully with a range of clients with different needs, had gained clients employment very quickly, thought outside the box and had continued to support clients when in employment.

There is much richer data on what made a difference for clients receiving IPS in Wave 2 and 3. Some clients who received IPS support felt that this was much more personalised than support from JCP. Clients felt that ESs were more down to earth, were more supportive, cared more about the clients and listened more closely to their preferences about employment. A few keyworkers also commented that ESs paid more attention to the jobs that clients actively wanted, rather than finding any job as quickly as possible, as was perceived to be the focus of JCP work coaches.

'[Compared to the work coach, the ES is] more motivating, more like a friend, and not annoyed with you if you don't find work.' (IPS client 25, opioids)

'I thought [the IPS trial] sounded good because if you go to the JCP, there is a lot of pressure on you. Because I get bad anxiety, the pressure doesn't help it so it's good to be able to talk to someone, and you can easily say "no" to stuff, and you feel that you don't have to take stuff or have to attend this appointment or your money will get stopped, so it's good having an impartial view from someone.' (IPS client 85, opioids)

'[My ES is] willing to listen, she seems more flexible than some I’ve talked to. It’s not just ‘how much proof have you got for doing 95 hours of job searches this week?’ And that whole thing frightens me. I get incredibly anxious.' (TAU client 61, alcohol)
‘The job agency will bring you down. But [the ES] will help you put yourself back together.’ (IPS client 77, other drugs)

Practically, clients reported that working with their ES was **more accessible and flexible** in terms of support than was possible at JCP.\(^493\) Clients had more time with their ES and could call them at other times\(^494\) and reflected that the relationship was more informal and relaxed.\(^495\) One client felt that their ES was more understanding than JCP because they understood the context of drug and alcohol difficulties.\(^496\)

In summary, the flexible and responsive nature of contact with ESs, and the ability to be honest with them and feel understood was highly valued by IPS clients. This was an experience that some TAU participants lacked but wanted. For example, one commented:

‘I’ve signed up to [recruitment agency] and a couple of others and they just email you so much. All the time. It overwhelms. My anxiety just gets over the top ... I don’t know how honest to be about myself. I don’t feel like you get the chance to talk about that.’ (IPS client 69, alcohol)

4.5.5. **Clients in the control group did not receive IPS but were signposted to other employment support**

Due to the nature of the trial, half the participants were allocated into the TAU control group upon joining the trial. Being in the TAU group meant that clients could not receive IPS support. Instead, clients could access the usual support that was available to clients at the treatment services and other employment services open to them, including the JCP.

As explored in section 4.1.5, keyworkers were not always comfortable with the idea of the control group.\(^497\) There was also some evidence that being in the control group was disappointing for clients.\(^498\)

‘I might forget who I had referred already and if I raised it again, [the client] remind me that they went into control and they feel like they missed out on something. They come from a background they’ve had several hard knocks, and this is just another one.’ (TSK 89)

A treatment manager explained that people who had volunteered for the trial had shown motivation, and suggested that even if they were randomised to control it was important for TSKs to keep the momentum going towards employment – not to focus on the negatives but to give them further contacts for help in the local area.\(^499\) In one site, a treatment worker commented that three clients who agreed to be put forward for the trial but were randomised to control, found work for themselves. The interviewee attributed this to these clients recognising from discussions about referral to IPS that their TSK and the ES believed that they were ready to work.\(^500\)

In Wave 2, SESs from almost all the sites reported that **there were employment programmes, placement projects or employer engagement schemes for clients who had either been allocated in the control group or had left the trial and were still looking for employment.**\(^501\) Similarly, some clients in the control group reported that they were **given information by their keyworkers about training courses to help them find employment**\(^502\) and employment support organisations they could contact for help.\(^503\) Information on these opportunities tended to be given via a leaflet or information sheet on sources of employment support that were developed for the clients in the control group and given out by the keyworkers.\(^504\) In Wave 3, two of the sites gave TAU clients some information about JCP provision and the Work and Health Programme.\(^505\) In one case, leaflets about an external employment service were provided.\(^506\)
’I always try to make it clear that if they end up in the TAU group there is a similar project which can help them. There is always a second option and they will not be alone to decide for themselves. Some of our clients are very vulnerable and they can be emotionally fragile.’ (TSK 7)

In Waves 2 and 3, most TAU clients who accessed employment support did so from the JCP, but (as explored in section 4.5.1) were largely dissatisfied with the JCP. Other TAU clients accessed employment support from elsewhere (as explored in section 4.5.3) including from charities, training and recruitment companies and other organisations.

It is worth considering whether the support offered to the control group was different to what they would have been able to access, had they not been on the IPS-AD trial. On the whole, clients in the control group were not offered more than the usual local employment offer, as demonstrated above, although we note that increased motivation of treatment services staff and clients to discuss and consider employment may have played a role (see section 4.6.3). We note, however, that there is only limited evidence that support for the control group went beyond what was usually offered to service-users. In Wave 2, one SES reported that they had begun offering general benefits advice more widely, rather than only to those clients in IPS. They explained that they did so in the hope of spreading the message that benefits would not necessarily be negatively affected by moving into work and thus to encourage referrals. While this might have helped increase referrals, we note that this activity had not been provided to treatment service clients on a regular basis and – if it were also open to the control group – ran the risk of changing what is considered treatment as usual (TAU).

We also note that the IPS-AD trial is a pragmatic trial meaning that the TAU offer varies between the sites and in its accessibility. Yet, we did find evidence that suggests that the trial might unintentionally have made a difference to what was being offered to the control group. We found limited evidence of support going beyond what was usually offered to service users. These findings may be important for the interpretation of the results in the impact evaluation.
4.6. Organisational processes that enable IPS in the specific context of treatment for alcohol and drug dependence

Box 12: Summary findings to EQ6 (what were the organisational processes that enable IPS in the specific context of treatment for alcohol and drug dependence?)

- There have been few major changes to treatment services organisation as a result of introducing IPS
- IPS teams had become more integrated and embedded in treatment services over time
  - Factors that helped the integration of the IPS team into the treatment services included co-location and good communication between IPS and treatment services workers
  - Being integrated was a key enabling factor for the success of IPS
  - Where integration was less strong, this tended to be because co-location had not been consistent, or because of changes in the IPS personnel
- There has been wider cultural change in how treatment services staff think about and deal with employment
- Collaboration between the ES and JCP has increased over the trial for most sites, but remains varied
  - There has been considerable variation across the sites in the relationship between IPS teams and JCP. This includes discussing specific clients with work coaches, building relationship with JCP partnership managers, awareness raising, requesting intelligence on the labour market and colocation
  - Barriers remained that limited the nature of collaboration – the main one being the low levels of disclosure of alcohol and drug dependence to JCP
  - Good practice for working with the JCP included having named points of contact, maintaining regular meetings and presence (both in JCP and the trial)
  - Collaboration with other services has remained consistent and a helpful addition to IPS provision.

4.6.1. There have been few major changes to treatment services organisation as a result of introducing IPS

Throughout all waves of interviews, many interviewees across nearly all sites reported that no major changes in treatment services processes had been required to enable IPS to function in the treatment services. Rather than any substantial alterations or addition of any entirely new processes, interviewees described small ‘add-ons’ or ‘little tweaks’ that allowed IPS processes to fit in around what already existed in the treatment services. Frequent changes included, for example, the inclusion of questions about employment in initial assessment forms and data recording. Where other changes in the organisation were noted, these related to the challenges of providing and organising training for new ESs, ensuring that the IPS workers could access the case management systems, fitting additional members of staff into small offices, and ensuring that IPS team members were included in
all team communication.\textsuperscript{515} For example, one stakeholder in Brighton noted that their upcoming scheme of having a JCP worker located in the treatment services for one day a week, who would be available to answer clients’ questions about benefits, had led to some additional work for the treatment services. This was because the stakeholder had to both host the JCP worker and remember to inform all clients (rather than just those on IPS) about the opportunity to talk to the JCP.\textsuperscript{516} This was, however, considered to be a minor concern.

‘[They] moulded the IPS [service] to look more like the treatment [services] rather than vice versa. Treatment services processes have been consistent with the IPS team ‘absorbed’ into the treatment services. They work for the service, sit with the TSK, work with the multi-disciplinary teams.’ (COM 90)

‘The trial has been in the mainstream to service but the way we responded to that is very similar with how we respond to other things... the way we incorporated the trial is very similar with the way we would do in other things. There isn’t anything at the moment that changed [due to] the direct result of the trial.’ (TSM 91)

Several ESs and keyworkers interviewed in Wave 2 from several sites reported that there were no particular areas where they felt improvements in these processes were needed\textsuperscript{517} and no interviewee in Wave 3 shared any further suggestions.

4.6.2. IPS teams became more integrated and embedded in treatment services over time

The integration of IPS workers with treatment services teams is a key principle of IPS. In the IPS model, integration is measured and achieved through the physical co-location of the ES’s work base with the treatment services team, the sharing of treatment plans and recovery monitoring systems, and a culture in which IPS workers are considered to be equal members within the treatment teams.

In both Waves 2 and 3, many interviewees reported that ESs were becoming increasingly integrated in treatment services over the course of the trial. Individual ESs became embedded in their treatment services teams, which typically included recovery workers and (depending on the type of service) clinical staff who were involved in the treatment of drug and alcohol recovery.\textsuperscript{518} By Wave 3, several ESs and keyworkers across some sites reported that the ESs were part of the core treatment services team and were included in team meetings, office-wide communication and working with clients.\textsuperscript{519}

‘We’re not treating the ES as a visitor coming in, they’re very much part of the team, they get included in all the information and communication, in all the activities and awaydays we do with staff. That’s what contributes to our success: we don’t see it as a bolt-on to the service but as another fundamental worker within the team.’ (TSM 2)

‘They are not two teams, they are one team, integrated wonderfully. Everybody is accessible to everybody and access to the case management system.’ (TSM 8)

This section explores the factors that helped and hindered integration in the treatment services. We also explore some disparities in integration noticed between sites, the reasons behind this and the ways in which challenges to integration were eventually overcome.
Factors that helped the integration of the IPS team into the treatment services included co-location, good communication between IPS and treatment services workers.

The factors felt to bring about the integration of the IPS team into the treatment services were closely linked to the factors that contributed to the successful implementation of the trial. This demonstrates the importance of the IPS principle that ESs should be integrated into the clinical teams for the successful launch of an IPS service. There are therefore several similarities between the facilitating factors described here and in section 4.1.5.

As was the case for encouraging referrals, the co-location of ESs with treatment services was considered by many interviewees to be an important factor in achieving integration throughout the trial. Co-location meant that ESs got to know staff members more quickly and on a more personal basis, and felt like part of the team and could take part in team meetings. All of this was felt to help their integration.

In particular, two interviewees from one site (Haringey), where ESs had been recruited three months before the start of the trial felt that being co-located with the treatment team from before the trial even began helped the ESs to start building relationships with the staff immediately. This was then helpful for joint working later on. In contrast, a few ESs from a site where full co-location was not in place from the beginning of the trial (Birmingham), felt that this had initially hindered their ability to work with TSKs in the same way. They reported that a shift to co-location had led to greater improvements in their integration.

Other factors that helped integration included having good communication between IPS and treatment services workers. Through attending team meetings and talking to colleagues, ESs were able to share good news stories, updates on referrals and on the trial’s progress, as well as discuss individual clients with keyworkers. A few interviewees felt that ESs being employed by the same organisation as the TSKs was helpful, both in terms of ESs feeling part of the team and there being straightforward organisational processes. Being employed by the same employer as the treatment services staff also helped ESs gain access to case management systems and enjoy smooth good information sharing practices. This, in turn, facilitated joint working between ESs and keyworkers on shared clients.

Furthermore, having strong treatment services management support for IPS was a facilitating factor because these managers could ensure consistent and positive messaging about how the IPS workers were part of the team. In addition, having ESs with backgrounds in the same sector, or who had known keyworkers before in a different role, was felt to help integration by some interviewees.

Being integrated was a key enabling factor for the success of IPS. Many interviewees from all sites and a variety of roles felt that IPS worked well because of the level of integration that had been achieved between the IPS services and the treatment services.

Having an ES in the treatment team acted as a constant reminder of the need to refer, of the importance of employment in recovery, and helped build up personal relationships. Practically, co-location and close working made elements of providing IPS support easier, because ESs could easily discuss clients informally with keyworkers and attend joint meetings with keyworkers, which meant that ‘warm handovers’ were possible and that clients did not have to travel twice for both appointments. A few interviewees reported...
that co-location helped ensure that the whole treatment team was supportive of IPS and felt a sense of involvement in and ownership of the IPS work.537

'I can’t remember the last time a member of staff came to me with questions about IPS because they can have that conversation with (the ES) in the office themselves. Any issues or queries are instantly resolved.' (TSM 92)

'So I guess the workers are part of our team, they come to the meetings, to the handovers and they are integrated into the team and that has been good and being able to have conversations with the clients in formal and informal ways is good.' (TSK 93)

'I like how it fits in with what I’m doing. When I’ve got my [keyworker] appointment, I can stay in and see [ES]; I can do it at the same place at the same time, and I can take as long as I want or as short as I want.' (IPS client 94, other drugs)

Where integration was less strong, this tended to be because co-location had not been consistent or because of changes in the IPS personnel

In some services, the integration of the IPS team into the treatment services teams was more challenging, often because co-location had not been consistent, or because of changes in the IPS personnel. In Haringey, interviewees reported that the integration of one ES in two treatment teams was less strong than the integration of the other ES in a single treatment team.538 A few interviewees attributed this to some characteristics of the first two treatment teams: some stakeholders reported that they were not aware of a consistent ES presence in the second team during the first year of the trial539 and others pointed towards other ongoing changes and factors affecting the personnel and culture of the other team. These included a change in team leadership, a reorganisation of the team, changes in contractual provisions, and the perception that historically the other team worked in a more disparate way anyway.540

In general, as explored in section 4.1.1, the fact that the ESs in Haringey were employed by a separate organisation to those providing the treatment services also caused some difficulties in terms of integration (and trial implementation) in this site.541

In Birmingham, full co-location was not in place from the beginning of the trial which was considered a key barrier to greater integration. A few ESs reported that a lack of co-location had initially hindered their ability to work closely with TSKs.542 ESs and other stakeholders reported that the shift that had moved ESs from a central office to be physically co-located within relevant teams in different local hubs had led to improvements in how integrated the ES felt and how easily they could work with keyworkers.543

'The IPS workers are with us on a few days a week, it is greatly improved from how it was before. They do cover a couple of hubs but when our worker is here […] a few times a week, […] she is here all day, so we know when she is coming in and we can speak to her personally it’s not just having to email.' (Birmingham stakeholder 2)

4.6.3. There has been wider cultural change in how treatment services staff think about and deal with employment in the IPS-AD sites

As explained in section 4.1.5, several interviewees in Wave 1 reported concerns that treatment services staff’s reluctance to consider employment as suitable for their clients acted as a cultural barrier to the implementation of the trial.544 545 Some interviewees did hope, at this early stage of the
trial, that keyworkers may be open to thinking about the role of employment in the future\textsuperscript{546} and that the trial would help raise the profile of employment as part of the recovery journey more broadly.\textsuperscript{547}

In line with these expectations, in Wave 2 and 3, many interviewees from all sites and a range of roles reported that they felt that the IPS-AD trial was making treatment services culture more conducive to conversations about employment for clients.\textsuperscript{548} Many interviewees reported that keyworkers were increasingly positive about IPS and about the role of employment in helping clients’ recovery from alcohol and drug dependence, rather than being an endpoint after recovery was complete.

‘[IPS has had a] massive impact in changing the culture. Staff and clients feel that we have made a difference, before we got here employment support had the lowest grading of things useful and available to clients and now it’s one of the highest graded things.’ (ES 26)

‘I think it has raised the agenda on employment. I think in this sector there is a lack of aspiration about employment and you always need to challenge clients to raise the issue of employment and increase aspiration AND I think there has been a cultural change because before IPS people were thinking that employment is something that happens after treatment but now they have understood that treatment helps employment and employment helps treatment goals.’ (COM 1)

‘The IPS trial has shown that you can tackle both unemployment and substance use at the same time and one might help the other.’ (TSK 89)

Other treatment services staff noted that they had already considered employment to be an important part of treatment but that the IPS-AD trial meant that this was easier to focus on.\textsuperscript{549}

‘It’s always good to support people into work, substance use is usually a symptom not a cause of unemployment and need.’ (TSK 95)

‘There is a substantial difference because before we used to ask them if they are in employment and this was as far as we got really. We are asking them if employment is something that they are want, looking at the future.’ (TSK 10)

There was little consensus around whether this shift in culture had contributed to a shift in how keyworkers worked with their clients. Some interviewees considered that there had been a practical change and noted that keyworkers initiated conversations about employment.\textsuperscript{550} Other interviewees, however, were unsure if this culture change had led to practical differences in how keyworkers worked with clients, beyond the requirements laid out by the IPS-AD trial to ask initial questions about employment more routinely and to refer to IPS more regularly.\textsuperscript{551} One ES felt that the trial had led to a greater emphasis on recovery-focused conversations for some treatment services staff, if not yet employment conversations,\textsuperscript{552} while other ESs noted that the culture change had had a particular impact on longer-serving NHS clinical staff rather than on recovery coordinators.\textsuperscript{553}

In a similar vein, some considered that the treatment services staff had gained more knowledge, contacts or resources around employment as a result of the IPS-AD trial.\textsuperscript{554} One interviewee reported that the treatment services staff had more contact with employment services and access to a list of relevant contacts put together by the ES.\textsuperscript{555} A few other ESs, however, felt that sharing this knowledge had been limited, and that they had instead focused on ensuring that TSKs
shared their conviction that employment was important and that the IPS team could help with this. Some Ess explained that this was because they were reluctant to share too much knowledge to avoid contamination of the control group of the trial and another explained that other time pressures on ES and keyworkers meant that finding time to share knowledge was difficult.

‘Keyworkers have significantly more knowledge on [the] benefits system, on supporting people with CVs, on supporting people into employment and in employment, with job interview prep, with the sort of employers locally who are willing to take on client group.’ (TSM 2)

The drivers of this culture change were generally not specified beyond the fact that the trial was running, the role of the ES, and interviewees’ observations that IPS was demonstrably helping some clients. Some interviewees emphasised that the highly embedded role of the ES in the team and the way in which they constantly and visibly promoted employment and the trial were important factors in this change. One SES reported that becoming so integrated and building these personal relationships had meant that their team now felt more confident about challenging the status quo and encouraging keyworkers to consider employment support for clients more regularly than before.

4.6.4. Collaboration between the ES and JCP increased throughout the trial for most sites, but remained varied

There was considerable variation across the sites in the relationship between IPS teams and JCP

Guidance was issued to JCP teams at the commencement of the trial explaining the services provided through IPS-AD, the way in which JCP work coaches should work with clients on the trial, and how the JCP might work with ESs. It is, however, not clear to what extent these were widely circulated by the DWP and understood at a local level.

Throughout the trial, relationships between JCP and IPS teams have developed unevenly across sites. While in Wave 1, all sites reported that relationships were at an early stage (especially between ESs and work coaches), by Wave 2 and 3, more variation between sites had emerged.

By Wave 2 and 3, some sites appeared to have further developed relationships with JCP, while in others, progress remained limited. Some JCP interviewees felt that cooperation and awareness about drug and alcohol having improved over time because of working with the IPS team. This was corroborated by some ES in the same sites, who considered that their growing relationships with key individuals at JCP had led to more awareness and collaboration.

In Brighton, the IPS service and JCP relationship was described as ‘blossoming’. The JCP staff have provided contacts with employers, information about the Access to Work scheme and the company Maximus, which delivers another employability programme.

‘It’s been a light bulb moment for a lot of people, as people get to know each other, their awareness grows. Some of our colleagues found it quite a threatening and scary area, but their confidence is growing.’ (JCP representative 96)

‘The relationship has been transformed: in the first year I didn’t find [the JCP] at all helpful or accessible, it felt like there was a willingness to want to help but then whenever I asked for information they were unable to provide it. But in recent months there has been transformation, we have spent a little bit more time understanding the needs of each other.’ (ES 26)
Other services did not report close relationships between the IPS team and the local JCP, including in Blackpool and Haringey, where collaboration was more limited. In these sites, ESs reported attending a few meetings at the JCP with a client upon request, providing some training to JCP staff, and giving clients letters about the trial to pass onto their work coaches. There was, however, little evidence of closer working than this, and JPC interviewees from both Haringey and Blackpool reported little knowledge of how the trial was going. A range of explanations for this were given, including reported declines in contact by the SES and JCP over the course of the trial, the large number of clients who were not on job-ready benefits and who consequently did not have a work coach limiting the type of relationship possible, and the JCP’s focus on Universal Credit. When speaking in Wave 3, however, there was some appetite for change and improvements in the last few months of the trial, and, in one of the sites, plans for action.

Collaboration between the JCP and IPS teams took several different forms

ES and JCP representatives described a range of ways in which they collaborated, including:

- **ES talking to work coaches about specific clients.** In Wave 1, much communication between ES and JCP staff involved alerting JCP to which clients were taking part in the IPS-AD trial so that a six-month automatic easement from benefit rules could be applied to trial participants. This would take eligible participants out of job-seeking conditionality so that they can focus on IPS. In Wave 3, some ES reported that they often worked jointly with work coaches on shared clients and would regularly inform the JCP when one of their clients joined the trial. Many ES, however, still reported that interaction with specific work coaches was ad hoc and only took place upon client request or to answer specific queries, usually around benefits.

  ‘But generally speaking [ES seeking to speak to work coaches] is the exception not the rule: we wait for the client to ask us to get in touch with the JCP instead.’ (ES 17)

- **Having named single points of contact on both sides.** Some ES reported that this would be helpful in further developing relationships with the JCP, particularly a named treatment services contact that JCP work coaches could use if they had concerns about a client’s drug and alcohol use.

- **Building relationships between IPS and JCP managers.** In Wave 1, relationships between SES and JCP partnership managers were reportedly stronger than those between ES and work coaches. Almost all SES had devised a strategy for engaging with JCP. In Wave 2 and 3, strong relationships in this arena persisted, with regular contact between managers in some sites through gateway or partnership meetings with other organisations undertaking similar work, joint meetings with the JCP and the COM, and semi-regular email and phone conversations. In some sites, the SES acted as the main point of contact, with ES and work coaches going through them to get in touch.

- **Ensuring JCP representation on local steering committees.**

- **Focusing on ES providing training/ awareness-raising about IPS in JCP.** In a number of sites, across waves, many ES reported that they had attended meetings or delivered presentations in order to inform JCP staff about IPS. This included one-off presentations, regular attendance at JCP meetings, and tours of the treatment
services for the JCP staff and similar tours of the JCP offices for ES to meet all work coaches. In these tours and meetings, ES explained to JCP staff what IPS was and emphasised how ES can help work coaches by providing an additional service for the same clients.

- **ES asking JCP for information about available training and vacancies.** Increasingly, as the trial continued, many ES from almost all sites reported that they heard about training courses, grants and vacancies for clients from JCP, often through mailing lists or attending specific events and forums. In one site, the IPS service officially signposted clients who were coming to the end of the time-limited support on the IPS-AD trial to the DWP’s Work and Health Programme. This signposting came about as a result of close working between the SES and JCP.

  ‘When it works well, it’s really positive, because we look at the job vacancies that they’re recruiting for through their email lists.’ (ES 11)

- **ESs working out of JCP offices and piloting having JCP work coaches working out of the treatment services.** In one site (Derbyshire), a few ESs reported working out of JCP offices to facilitate covering a large area. These ESs reported that this helped them get to know a large number of JCP work coaches and helped JCP work coaches learn about the IPS-AD trial. In addition, this arrangement ensured that ESs could have ‘warm handovers’ with the JCP work coaches and arranged to meet the clients straight after their meetings with JCP work coaches, to facilitate client attendance and engagement with ES. A few ESs, however, felt that this co-location had not necessarily led to as much awareness amongst JCP staff about IPS as desirable, with several work coaches reportedly still unsure about what the trial involved. Although the ESs also stressed that this was not necessarily a problem. ESs in another site (Brighton) reported that they had tried to work out of the JCP city-based site, but that clients were not willing to have extra appointments there.

  Barriers remained that limited the nature of collaboration – the main one being the low levels of disclosure of alcohol and drug dependence to JCP.

  While interviewees from the IPS teams were largely positive about the level of collaboration with the JCP in Wave 1 interviews, several JCP interviewees reported that they were not clear which job-ready benefit claimants were on the IPS-AD trial and did not have regular communication with ESs. While relationships did improve over the course of the trial through more close working, barriers to collaboration were also reported in Wave 2 and 3 interviews. These included:

  - **Clients’ reluctance to disclose to JCP** the fact that they were in treatment for alcohol and drug dependence. Across all waves, many ES and JCP staff cited clients’ unwillingness to disclose their treatment status to JCP work coaches as a barrier to greater collaboration with the service. This may be related to the fact that many clients interviewed demonstrated a dislike or distrust of the JCP (as discussed in section 4.5.1). When a client would not disclose to the JCP, ES were not able to talk about specific clients with JCP staff.

  - **Competing priorities of the JCP.** One site with only sporadic contact with the JCP reported that this was due to the JCP’s focus on Universal Credit.

  - **Staff turnover in an IPS team** and the inability of JCP staff to directly refer onto the trial was perceived as a
Collaboration with other services has remained consistent and a helpful addition to IPS provision. Many ESs from all sites reported some levels of collaboration between the IPS team and a variety of other services in both Wave 2 and 3 interviews. At no point, however, in the waves of interviews did any ES report that building these relationships was something they considered a priority or entered into systematically. ESs sometimes referred clients to other services (including council services, third-sector organisations or companies) in order to help specific clients with:

- Developing their employment abilities through job coaching or specific employment support or the provision of education and training
- Ensuring suitable and safe housing situations
- Addressing mental health needs
- Providing benefits advice
- Providing suitable work outfits
- Offering family support and debt advice.

Most liaison was around specific clients and their needs. Only a few interviewees described more general relationship-building work with housing organisations (such as giving them a tour of the treatment services) and a community organisation focusing on eradicating poverty. Barriers to working with other services in this way included the fact that ESs could not refer directly, but instead had to liaise with keyworkers in at least one site, as well as the way in which safeguarding measures, such as ensuring that clients consented to their data being passed onto other organisations, sometimes stymied greater collaboration.
4.7. Identifying participant characteristics that are best suited to IPS

Box 13: Summary findings to the EQ7 (were there participant characteristics that are best suited to IPS?)

- A targeted review of literature shows that across all three substance groups, completing treatment improves chances of employment and being in work increases prospects of completing treatment successfully
- There was no consensus among interviewed stakeholders on specific characteristics that make it easier (or more difficult) for clients to engage with IPS
- Strong motivation to work and stability in clients’ recovery are key to engage with IPS
- Stability in other areas of life makes it also easier for clients to benefit from IPS but other factors are difficult to identify.

4.7.1. A targeted review of literature shows that across all three substance groups, completing treatment improves chances of employment and being in work increases prospects of completing treatment successfully

Before presenting interview findings in relation to this question, we start by outlining the evidence of the relationship between treatment and employment for people with alcohol and drug dependence more broadly, and the factors associated with finding employment across the three substance groups. In doing so, we rely primarily on the analysis presented in Dame Carol Black’s review into the impact on employment outcomes of drug or alcohol dependence.625 This was based on the 2014/15 NDTMS data matched with the 2011/12 Labour Market System data.

This evidence provides context to the interview findings that capture perceptions of stakeholders on participants’ characteristics best suited to IPS. It also points to characteristics that are associated with chances for securing employment. In highlighting those characteristics, we do not recommend that IPS should be offered selectively to only those people who share these specific characteristics. On the contrary, one of the IPS principles is that it is open to every person who wants to work, regardless of diagnosis, symptoms, work history, or other problems. Awareness of the evidence base, however, may help ESs better anticipate the particular challenges associated with their client base in the future.

There is broad evidence showing the relationship between dependence treatment and employment.626 Analysis of data carried out for the Black review shows that completing treatment improves the chances of finding employment (Figure 5). For opiate, non-opiate and alcohol users, the rate of employment for those leaving treatment successfully were approximately two times higher than for those leaving treatment in an unplanned way.
We also know that being in work (be it irregular, part-time or full-time) at the start of treatment increases the likelihood of completing treatment successfully across all three substance groups (Figure 6).

The Black review points to characteristics associated with individuals at the start of treatment, which can predict whether a client will be in employment when they exit the treatment system. Across all three substance groups the main predictors of whether clients will be in employment when they leave treatment include: (i) being in any paid work at the start of treatment, (ii) being male, (iii) being in good physical or psychological health.

By the same token, factors negatively associated with being employed at the end of the treatment across all three substance groups...
groups include: (i) living in the most deprived areas, and (ii) having had multiple previous attempts at treatment. For opiate clients, housing issues formed another strong negative predictor.629

Factors associated with an increased likelihood of clients finding employment during treatment across all three substance groups include: (i) being male, (ii) being younger (than 33 years old for opiate clients, 28 years old for non-opiate clients, 35 years old for alcohol clients), (iii) being in better physical or psychological health, (iv) having used alcohol or drugs for shorter periods of time and (v) living in less deprived areas.630

The analysis also finds that across all three substance groups the longer the period of staying on benefits, the poorer the chances of starting work: for each year on benefits the likelihood of gaining employment falls by 10% for opiate clients, and 23% for alcohol clients.631

4.7.2. There was no consensus among interviewed stakeholders regarding specific characteristics that make it easier (or more difficult) for clients to engage with IPS

This discussion draws on interview findings and relates them to characteristics that affected how clients engaged with IPS. As demonstrated, the opinions of interviewed stakeholders varied greatly and contradicted each other. These findings have also not been corroborated by the analysis of context, mechanism and outcome patterns, which can shed more light on what might be more effective for which groups of clients.

In terms of the levels of engagement with IPS, a few interviewees in Wave 2 could not point to any major differences between the three main substance groups.632 Many ESs and keyworkers, however, representing almost all sites in Wave 3 perceived some differences in terms of substance groups or stages of recovery,634 even if their observations were sometimes contrary.

Looking at the substance groups, some interviewees felt that clients who fell into the alcohol-only group were more likely to look for work and to engage with IPS.635 Yet, this view was explicitly contested by others who held exactly the opposite opinion.636 Interviewees who felt that alcohol users were easier to engage using the IPS service reasoned that these clients tended to have less chaotic lifestyles.637 The counterargument expressed by other interviewees highlighted that the long-term nature of their alcohol and drug dependence and associated social stigma undermined clients’ motivation.638

Another group of interviewees thought that opiate clients were less stable and less likely to accept IPS support.639 According to the interviewees, opiate users were more likely to have chaotic lifestyles,640 were less motivated to work, and had lower levels of self-belief.641

There were, however, individual interviewees who expressed contrary opinions, and felt that the opiate clients were more likely to engage with IPS,642 more motivated to work643 or better able to control their substance use and fit it around employment than those using other substances.644

Finally, another set of stakeholders was almost equally divided into those who felt that clients using other drugs are more or less likely to engage with IPS.646 According to these interviewees, other drugs generally had a smaller effect on clients’ lifestyle and their general abilities.547 Some felt that the effect of such drugs was simply different (and less challenging) and that clients in these groups were likely to experience periods of stability and periods of instability as a result of their drug use.648 Those who held the opposite view noted that any engagement with some clients (rather than specifically for the IPS service)
would be difficult because their attendance could have been court-mandated, and they would thus be less motivated to engage.649

4.7.3. Strong motivation to work and stability in clients’ recovery are key characteristics of clients who engage with IPS

As noted earlier, lack of confidence (section 4.3) and practical problems (section 4.4) were all identified by clients and other stakeholders as barriers to employment. When these issues were addressed, interviewees felt there are more chances of success. Rather than specific characteristics or substance groups, many interviewees noted that the level of engagement with IPS depended largely on client motivation and confidence in finding a job650 or on support being provided at the right time, once their more basic needs such as housing had been addressed.651

‘When our clients are ready, that’s when they’re ready, they’ve put a lot of work into getting ready, into being abstinent … and it’s then that they have the most motivation, it’s then that we as workers need to be able to book them in. It needs to be almost immediately, next week, maximum of two weeks later, if you’re not sure when the employment worker will be in then everyone loses motivation.’ (TSK 97)

‘The more chaotic the lifestyle, the less likely they are to attend [IPS meetings].’ (ES 98)

More of a consensus emerged when interviewees discussed whether there was a stage of recovery at which clients were more likely to engage with IPS. Most stakeholders in almost all sites and roles, said that clients who are in treatment, who are stable and in recovery were more engaged with IPS.652 This was because these clients were generally engaging more with treatment,653 because being at a stable stage of recovery was linked to a lower level of drug use,654 and because clients had more time to think about IPS and employment in their recovery.655 Still, there was another view that no one point in a client’s recovery journey was particularly well suited for engaging with IPS.656

4.7.4. Stability in other areas of life also makes it easier for clients to benefit from IPS but other factors are difficult to identify

The interview findings suggest that stability in a recovery journey appears to be associated with stability in other areas of life. Clients who have stability in other areas of their life are also more likely to benefit from IPS.657 Having a stable housing situation,658 a suitable support network,659 stable family relations,660 and a level of stable income (whether from benefits or elsewhere)661 allows people to have the time and energy to engage with the IPS service. Beyond general stability in recovery journey and life, it seems that there was no clear pattern in terms of characteristics of clients who might benefit from the IPS service. Many stakeholders, representing all sites and different roles, found it very difficult to point to those clients who would benefit most from IPS.662 Those who observed some differences between their clients again had conflicting opinions. Some felt that opiate663 and alcohol users seem to get into work more easily than others,664 and so benefited from IPS support more. Others, however, held exactly the opposite view.665 Similarly contrasting opinions related to the levels of confidence among the treatment clients – that less motivated or less confident and more vulnerable clients seem to benefit more,666 or that it is mainly clients who have self-confidence and determination who benefit more.667

‘IPS works best for those who really want to work, if they have the determination,
whereas other clients are just saying what they think you want to hear – yes I want to work, to get the Jobcentre off their back, but their heart isn't in it.' (ES 99)

'Clients who tell me they don’t know where to go for support are the ones who are most likely to benefit from this sort of thing. Those who might not have the best relationship with the JCP or services in generally are the ones who the IPS service can have the most impact on and who can get the most out of it’. But these clients often come in quite mistrustful and frustrated and are least likely to engage with us.' (ES 100)

'They don't need to go to a job forever but they just need to understand that they can go to a job interview, they can apply for a job that it is interesting and maybe work once a week to see what it is like. I always encourage my clients to be involved with volunteering, because it doesn’t affect their benefits, and do couple of days a week: not about the income but about the social relationships and being helpful. It is just a lot of aspects of working other than earning.' (TSK 7)

The discussion presented above was based on perceptions of stakeholders and as such, it cannot be considered as objective. On the contrary, it is prone to many limitations and is provided to illustrate the diversity of opinions that are held, rather than to establish characteristics that are most or least suited to IPS. It is expected that the impact evaluation to be carried out by PHE will provide sub-group analysis of the quantitative outcome data shedding more light on any differences within and between the group of IPS participants.
4.8. Implementing IPS in the specific context of treatment for alcohol and drug dependence

Box 14: Summary findings to EQ8 (how can IPS best be implemented for the target population in the specific context of treatment for alcohol and drug dependence?)

- Fidelity reviews showed no structural or systematic issues with IPS implementation in the context of treatment services
  - Sites generally performed well in terms of the fidelity items relating to how their staffing structure was set up
  - Almost all sites had a strong organisational set up or demonstrated the potential to achieve this at a later point
  - Job development, follow along supports, community-based services and assertive engagement and outreach were the IPS elements that were most challenging to implement adequately across all sites
- IPS principles were easily applied in the context of drug and alcohol treatment services
- The length of the IPS support offered and the speed of engaging clients with a job search were the only aspects of the IPS model that were questioned in terms of their appropriateness (and only infrequently)
- There is wide support for IPS-like employment services but funding considerations play an important role.

4.8.1. Fidelity reviews showed no structural or systematic issues with IPS implementation in the context of treatment services

As discussed in section 4.1.1, by the time of writing, all trial sites have reached good or fair fidelity. Drawing on the most recent fidelity review reports for all sites, this section takes a closer look at whether any aspects of IPS have been particularly challenging to implement in the specific context of treatment for alcohol and drug dependence by examining performance in each of the 25 fidelity criteria. We note that these fidelity reviews were not undertaken as a data collection method but rather, as discussed in section 2.2.2, as a tool for identifying areas in which quality of practice could be improved for the sites. While we examine scores gained by sites in each area, individual scores are only useful as pointers to areas where the site should look to improve what they offer, rather than definitive rulings on quality.

Table 8 illustrates the scores achieved by sites against individual criteria in the second round of fidelity reviews undertaken in late 2019 after approximately 16 months of delivery. The ‘sea of green’ indicates that most items have been either fully or adequately implemented across all the trial sites, even though some terminology (for example, community mental health trust, CMHT) refers to IPS in its traditional context of mental health services. Table 9 shows the change in scores achieved by sites between the first and second rounds of review. A more detailed analysis is provided below.
Table 8: Scores received for each fidelity review item by each site in Round 2 fidelity reviews

<table>
<thead>
<tr>
<th>Item</th>
<th>Birmingham</th>
<th>Blackpool</th>
<th>Brighton</th>
<th>Derbyshire</th>
<th>Haringey</th>
<th>Sheffield</th>
<th>Staffordshire</th>
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<td>1</td>
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<td>Integration with CMHT through team assignment</td>
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<td>4</td>
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<tr>
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<td>Integration with CMHT through frequent contact</td>
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<td>5</td>
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<td>5</td>
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<td>103</td>
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Note: Services are awarded a score between 1 to 5 for each item depending on meeting specific criteria set out for each. However, in general, a score of 5 means that an item is fully implemented and a score of 4 means that an item is adequately implemented (marked in green). Scores of 3 (marked in yellow), 2 and 1 (marked in red) indicate that the item is inadequately implemented to varying degrees. If information cannot be found to score an item, then a score of 1 is given.

Sites generally performed well in terms of the fidelity items relating to how their staffing structure was set up. The first three items on the fidelity scale focus on staffing and examine the number of cases held by the ES (item 1), the type of work undertaken by the ES (item 2) and the extent of specialism between ESs in a team (item 3). Most sites scored highly in all three items, indicating that overall, the staffing structures and profiles in place were suitable.

- All sites except Birmingham had scores indicating a **caseload size of 20 or fewer** (item 1). Higher than usual caseloads in Birmingham were due to staff shortages, which, once resolved, would have brought the number of clients per ES to more adequate levels.
- ESs in all sites **offered only employment support** (rather than treatment support or support for other non-employment related issues), and scored well on item 2. This score might be higher in non-trial settings, as some of ESs’ time across all sites was spent on trial-related activities (such as administration, communication with PHE, and follow-up questionnaires), which are not part of standard IPS practice.
- All sites scored well on item 3, indicating that **ESs carried out all or nearly all phases of employment service** (intake, engagement, assessment, job development, job placement, job coaching, and following along supports). The only exception to the overall trend was Haringey, where fidelity reviewers found that the whole pathway of IPS could be better documented. This would include the process of supporting people during their job start phase and offering/providing follow on support.

Almost all sites had a strong organisational set up, or demonstrated the potential to achieve this at a later point. Items 4 to 11 on the fidelity scale examine the organisational set up of the IPS service. This includes:

- Integration with treatment services through team assignment (item 4)
- Integration with treatment services through frequent contact (item 5)
- Collaboration with JCP and DWP commissioned services (item 6)
- Whether the IPS team functions as a unit (item 7)
- How the work of ESs is supervised (item 8)
- Whether any eligibility criteria are used when referring clients to IPS (item 9)
- If the focus is on competitive employment (item 10)
- Executive team support for supported employment (item 11).

All sites demonstrated evidence that ESs have a caseload that went across no more than two treatment services teams (item 4), and that ESs were **well integrated with the alcohol and drug dependence treatment services teams**. ESs across all sites had **frequent contacts with treatment service teams** (item 5). They attended weekly client-focused meetings with the treatment team, participated actively in the team meetings, and helped the team think about employment for people who have not yet been referred to IPS. This also means that employment services documentation was integrated into the client’s treatment record and that ESs worked near (or with) the treatment team (co-location). This aligns well with the interview findings discussed in section 4.6.2.

The fidelity reviews also indicated that most sites demonstrated evidence of good
collaboration between the IPS team and mainstream employment services and programmes (item 6). This collaboration implies having scheduled, regular, face-to-face general meetings or weekly client-related contacts with the JCP. Only in Haringey and Sheffield were such meetings or contacts found to be less frequent (quarterly or monthly).

The improvements in this respect were also noted in section 4.6.2, which nonetheless highlighted more diversity of practices across the sites than are reflected in fidelity review scores.

In most sites, the IPS service worked as a team (item 7) with at least two ESs and a team leader who formed an employment unit and covered for each other’s caseloads when needed. The teams met a few times a month for client-based group supervision in which strategies were identified, job leads were shared, and clients discussed within the team. Birmingham scored lower for meeting less frequently (attributed to ESs working across the city’s distant locations), and Haringey scored lower because it had been operating with only two ESs (the third position was vacant at the time of writing).

Almost all sites demonstrated that the key roles of the employment supervisor (fulfilled by the SES in the IPS-AD trial) were in place (item 8). These roles include: overseeing a limited number of ESs; conducting weekly supervision; communicating with treatment team leaders and attending treatment team meetings; accompanying ESs who are new or having difficulty with job development; and reviewing client outcomes and setting goals to improve the service performance. This item proved more difficult for Birmingham (where some supervisory roles needed further development) and for Haringey (where the supervisor role changed several times).

All sites showed that all clients interested in working had access to IPS (item 9). The fidelity reviews also noted that TSKs encouraged all eligible clients to consider employment.

These findings contrast with the interview findings presented in section 4.1.5 which showed that keyworkers were using some discretion (beyond the inclusion / exclusion criteria) in referring clients throughout the trial, albeit to a lesser extent in the later stages (Wave 3). These differences in response could be explained by the different contexts of fidelity reviews and independent evaluation interviews. Fidelity reviews triangulate information captured through interview with different sources of information (including through observations, reviewing meeting minutes, reviewing other documentation). The fidelity reviews also took place at a different time and likely involved different interviewees to the evaluation interviews, which might explain the differences. In addition, evaluation interview questions (see Annex A) focused on interviewees’ opinions about clients’ ability to work (as well as whether or not they referred all eligible clients), while fidelity review questions typically focus on keyworkers’ referrals, rather than their opinions. Furthermore, interviews that took place for a fidelity review had more explicit implications for the IPS service and treatment services (in terms of affecting the fidelity score received) whereas the interviews for the evaluation were independent and unrelated to future outcomes for the individual or the services. All of this may go some way to explaining the difference in the information provided by interview analysis and in the fidelity review reports.

The fidelity scale looks for evidence of a strong focus on competitive employment by the whole treatment services organisation, beyond the IPS team and the relevant treatment team (item 10). With the exceptions of Brighton and Haringey, all sites demonstrated a strong focus and promoted competitive work through multiple strategies.
It should be noted, however, that Brighton and Haringey only needed to demonstrate that they used one particular mechanism (sharing more successes stories with treatment teams) in order to score more highly.

Finally, nearly all sites enjoyed strong support from their executive teams (item 11). Haringey, which again scored slightly lower, had a distinct organisational set-up, where the IPS provider and the treatment provider are separate organisations and are not organised into a consortium. This means that it was more difficult to evidence the executive team’s support and explains the lower score. It was, however, possible to evidence this support in Blackpool and Derbyshire, where the organisational set up was similar.

Overall, the fidelity reviews show that there were no structural or systematic issues that would prevent the implementation of IPS in the context of treatment for alcohol and drug dependence, despite differences in how these services are organised. The challenges faced by Haringey, which scored lower in a number of items, often related to the IPS team being short-staffed and could have improved if the vacant ES position was filled.

Job development, follow along supports, community-based services and assertive engagement and outreach were the IPS services that were most challenging to implement adequately across all sites. All trial sites achieved top or second-best scores for several IPS fidelity items, including:

- Work incentives planning (item 12) that focuses on counselling on all sources of income, all types of benefits and all costs associated with commencing or changing employment.
- Vocational assessment (item 14) that starts early and is updated with information on preferences, skills, strengths, work experiences, current adjustment, etc.
- Diversity of job types (item 19) and diversity of employers (item 20) which reflect ESs’ efforts to support clients in obtaining jobs that align with their individual preferences.
- Competitive jobs (item 21) that indicates ESs provide job options that have permanent or semi-permanent status; pay at least the minimum wage; and are open to applications from anyone (rather than sheltered or set aside for example for people with disabilities).

Nearly all sites scored highly in terms of:

- Discussing disclosure with clients (item 13) (as mentioned also in section 4.2.2 and 4.2.5)
- Carrying out a rapid job search (item 15), where the first face-to-face employer contact by the client (or by the ES in relation to a competitive job) occurs within 30 days from the first meeting
- Carrying out an individualised job search (item 16), which again demonstrates that ESs look for employers that would match client’s preferences and needs, rather than open opportunities on the job market.

Other IPS fidelity items, however, proved difficult to implement as intended for most of the trial sites. These include: job development, involving both frequent employer contact (item 17) and the quality of those contacts (item 18); individualised follow-along supports (item 22); time-unlimited follow-along supports (item 23); community-based services (item 24); and assertive engagement and outreach by the integrated team (item 25).

Job development (items 17 and 18) focus on employer contacts and their quality and is one of the unique features of IPS that differentiate it from other forms of employment support. According to the IPS model, ES should make
at least six face-to-face employers contacts per week on behalf of clients looking for work. The relationships with employers should be built through multiple visits in person to learn about the needs of the employer, to convey what IPS can offer to the employer and describe client strengths that are a good match for the employer. Engaging with employers, however, and creating job opportunities for clients, remained one of the weakest areas of IPS practice across all trial sites (see section 4.2.5). We note that this is not unique to implementing IPS in the context of treatment services. Items such as job development tend to score low also in the context of providing IPS in mental health settings. For example, fidelity reviews carried out as part of the IPS Grow evaluation showed this remained at an early stage in almost all reviewed sites scored low and reported that they considered employer engagement to be particularly challenging.

Providing follow-along support is another unique feature of IPS. The individual character of this support is reflected by the different types of in-work support on offer that take into account the job demands, client preferences and needs. This support can also be provided by a variety of people, including mental health support and clinicians, family and friends, co-workers and ESs, who can assist the client with career development or job duties, as well as provide support to the employer. The evidence, however, on implementing these requirements as intended was limited across all sites. Some sites noted that clients did not request much ongoing support, which may be linked to the low levels of disclosure to employer (see section 4.2.2). If provided, such support was provided by telephone, text or email, rather than on a face-to-face basis. The fidelity review reports offered a range of recommendations from discussing the benefit of ongoing support with clients, developing in-work support plans with clear timescales for follow-up support, and developing offers for employers with information on employing people in recovery.

The low scores for time-unlimited support can be partly explained by the implementation of IPS in the trial setting. IPS-AD implemented the model trialled in the IPS-LITE trial wherein participants cease to receive IPS if still unemployed at nine months or after four months of in-work support, and thus was bound to score low on this item (also discussed in section 4.8.3).

Most trial sites also scored low on community-based services (item 24) which strives for employment services such as client engagement, job finding and follow-along supports to be provided in natural community settings. Only two sites (Brighton and Staffordshire) demonstrated that at least 50% of ESs’ time was spent in the community and fidelity reviews commonly recommended that other sites combine employer engagement and service user meetings to improve this metric.

Assertive engagement and outreach (item 25) touches on issues discussed in section 4.1.6. IPS support should not be terminated based on missed appointments or fixed time limits. Engagement and outreach attempts, including home and community visits or working with families, should be made by treatment staff and ESs. Three trial sites (Birmingham, Derbyshire, Sheffield) demonstrated that they had implemented this item well or adequately, but others had found this criterion difficult to meet (or to document). In some sites (Brighton, Staffordshire) limited capacity of treatment staff or no practice of home visits was provided as an explanation.

To conclude, the analysis of fidelity review results shows that:

- Most challenges faced by the trial sites seemed common to implementing IPS in any setting, rather than being unique to
community drug and alcohol dependence treatment.

- Some aspects (for example, job development and assertive engagement and outreach) showed improvement in scores between the first and second review in most sites (see Table 9), which demonstrates a potential to reach higher scores over time by a variety of services for treatment dependence.

- Some elements are interlinked and improvements in one item may help make progress in another category (job development and community-based services is perhaps the most evident example).

- Even those IPS services that prove particularly challenging to implement well (such as individualised follow-along support, community-based services and assertive engagement and outreach) have their champions among the trial sites making it possible to learn from others’ experiences and practices.
Table 9: Overall scores improved between reviews, but individual items changed in different ways, with some remaining the same

<table>
<thead>
<tr>
<th>Item</th>
<th>Birmingham</th>
<th>Brighton</th>
<th>Derbyshire</th>
<th>Haringey</th>
<th>Sheffield</th>
<th>Change</th>
</tr>
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<tbody>
<tr>
<td><strong>Staffing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1  Number on caseload</td>
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<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0.2</td>
</tr>
<tr>
<td>2  Employment Services Staff</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>-1</td>
<td>0</td>
</tr>
<tr>
<td>3  Vocational Generalists</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Organisation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4  Integration with CMHT through team assignment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5  Integration with CMHT through frequent contact</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0.2</td>
</tr>
<tr>
<td>6  Collaboration between ESs and JCP/WP</td>
<td>1</td>
<td>1</td>
<td>-1</td>
<td>0</td>
<td>0</td>
<td>0.2</td>
</tr>
<tr>
<td>7  Vocational unit</td>
<td>-2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-0.2</td>
</tr>
<tr>
<td>8  Role of employment supervisor</td>
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<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>9  Zero exclusion criteria</td>
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<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td>10 Mental Health Trust focus on competitive employment</td>
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<td>0</td>
<td>2</td>
<td>1</td>
</tr>
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<td>11 Executive Team support</td>
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<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Item</td>
<td>Services</td>
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<td></td>
<td></td>
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<td></td>
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<td>---</td>
<td>---</td>
</tr>
<tr>
<td>12</td>
<td>Work incentives planning</td>
<td>-1</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>13</td>
<td>Disclosure</td>
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<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>Ongoing, work-based vocational assessment</td>
<td>1</td>
<td>1</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15</td>
<td>Rapid search for competitive job</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
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<tr>
<td>16</td>
<td>Individualised job search</td>
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<td>0</td>
</tr>
<tr>
<td>17</td>
<td>Job development – Frequent employer contact</td>
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<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>18</td>
<td>Job development – Quality of employer contacts</td>
<td>-2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>19</td>
<td>Diversity of job types</td>
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<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>20</td>
<td>Diversity of employers</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>21</td>
<td>Competitive jobs</td>
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<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>22</td>
<td>Individualised follow-along supports</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>23</td>
<td>Time-unlimited follow-along supports</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>24</td>
<td>Community-based services</td>
<td>-3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>25</td>
<td>Assertive engagement and outreach by integrated team</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>-1</td>
</tr>
<tr>
<td></td>
<td>Total change in score</td>
<td>9</td>
<td>20</td>
<td>10</td>
<td>11</td>
<td>10</td>
</tr>
</tbody>
</table>

Note: No data for Blackpool and Staffordshire. Items where an average increase across the sites was equal or above 0.8 points are marked in blue.

4.8.2. IPS principles were easily applied in the context of drug and alcohol treatment services

Selected interviewees (mainly ESs) were asked whether the principles of the IPS model (see section 1.1) had been adapted to suit the site circumstances and the specific context of treatment for alcohol and drug dependence. Many stakeholders across almost all sites reported that **no adaptations were needed** to IPS and that the service was easily applied to people with alcohol and drug dependence and in the context of treatment services.\textsuperscript{670, 671}

With the exception of certain features required by the trial set-up (for example, time-limited support, formal inclusion and exclusion criteria) and the use of some implicit criteria by some keyworkers in deciding who to refer to the trial (as discussed in section 4.1.5), no deviations from the eight principles were recorded and all sites attained at least fair (and often good) fidelity scores (see section 4.1.1).

As already noted above (section 4.8.1), some stakeholders felt that the language of the fidelity scale and set up of fidelity reviews were not well suited for implementing IPS in the context of treatment for alcohol and drug dependence. This was due to the fidelity’s focus on mental health. This was, however, not considered to be a major problem.\textsuperscript{672}

‘A lot of the language in the fidelity scale is geared around the mental health side of it. One is specifically that ES attend multi-disciplinary meetings and discuss different clients with wider clinical team: while this does happen in the AD services, not all clients are discussed in these meetings (only the riskier ones). This means that ES’ clients aren’t usually discussed in these meetings.’ (ES 88)

4.8.3. The length of the IPS support offered and the speed of engaging clients with a job search were the only aspects of the IPS model that were questioned in terms of their appropriateness (and only infrequently)

The one issue that was highlighted by some ESs related to the length of the IPS support offered and the speed of engaging clients in job search.\textsuperscript{673} One ES thought that the nine month period for providing IPS support to clients with alcohol and drug dependence might be too short for this group.\textsuperscript{674} This was also mentioned by one participant, but they pointed to a slow response from the ES, rather than the intervention being of too short a duration.

‘We rewrote my CV, which was one of the most helpful things. We didn’t get further than trying to work out the benefits and writing my CV. The benefit calculator didn’t apply because my situation is unusual. ES knew someone to contact but couldn’t get hold of them before the nine months I had on the trial ran out.’ (IPS client 31, alcohol)

The rapid job search in IPS starts within 30 days to show to clients that their desire to work is taken seriously. In Wave 1, a few ESs considered that this period required some more flexibility.\textsuperscript{675} This is because the prospect of job interviews within weeks could be intimidating for someone who has never worked.\textsuperscript{676} In particular, it was felt that there was a risk of disengagement by pushing a client too hard in the early days, and that it could take a few sessions with clients to build a relationship, move past discussions about their issues and barriers to employment and develop a CV.\textsuperscript{677}

It should be noted, however, that these issues were raised by a relatively few interviewees and mainly at the start of the trial.
4.8.4. There is wide support for IPS-like employment service but cost considerations play an important role

Many stakeholders from various roles and many sites interviewed in Wave 3 reported they were hoping to implement IPS-like employment services once the trial ends and to see a wider culture change in integrating employment with recovery.\textsuperscript{678} The interviewees, including treatment services staff, acknowledged the efforts invested in the integration of IPS with treatment teams,\textsuperscript{679} saw the need for ESs working alongside treatment staff for their clients in the future,\textsuperscript{680} and noted the change in treatment services.\textsuperscript{681}

‘The team have got used to IPS workers being there and us “nagging” them to offer IPS, that it’s become part of our process… For me it’s changed the service round to a more empowering approach, for me it’s been amazing.’ (TSM 101)

‘Our concern is what happens after [the trial because] we have built up a great expectation that we can get people back into employment… I see IPS replacing what we had before, it needs to form part of that treatment pathway.’ (COM 102)

‘The momentum is there now and we want to continue without losing the momentum, otherwise if it stops and then we decide we should start it up again, we have to do the whole integration piece again.’ (TSM 8)

Several commissioners, however, from a range of sites raised cost considerations and the need for the IPS-AD trial to demonstrate value for money of the service in the context of treatment dependence.\textsuperscript{682} Some of them reported that without extra funding – be it from central government, local Clinical Commissioning Groups (CCGs) or other avenues – sustaining an IPS service would not be possible.\textsuperscript{683} Provision of additional funding for any further employment services was considered important due to competing demands on treatment staff who would not be able to offer the same level of engagement with employment after the trial, especially within the context of shrinking budgets.\textsuperscript{684}
4.9. Contexts, mechanisms, and outcomes patterns that describe how IPS works in the specific context of treatment for alcohol and drug dependence

Box 15: Summary findings to EQ9 (what are the contexts, mechanisms, and outcomes patterns that describe how IPS works in the specific context of treatment for alcohol and drug dependence?)

- Evaluation findings broadly support the ToC models and point to areas where more clarity is needed, or which could be further validated in the future
  - IPS specialists working with treatment teams: the readiness of keyworkers to refer clients to the IPS service is equally important as their knowledge of how to do it
  - From activities to outputs: findings validated the importance of improved confidence and increased motivation
  - Most the anticipated outcomes and impacts are yet to be validated
- Mechanisms and contexts in the IPS-AD trial – what makes IPS work
  - Macro mechanisms address the capability of treatment clients to secure competitive employment (that is, mechanisms that provide clients with necessary resources)
  - Micro mechanisms address the choices that treatment clients make (that is, mechanisms that might affect the way clients think and reason)
  - Contexts set by social rules, norms, values or interrelationships, may trigger or stop the intended mechanism(s) of change.

4.9.1. Evaluation findings broadly support the ToC models and point to areas where more clarity is needed, or which could be further validated in the future

The ToC models (Figure 9, see Annex B) that underpin our evaluation, outline our initial understanding of how the available resources and activities delivered were expected to result in the desired outcomes and impacts.

Below, we comment on whether the evidence gathered during the evaluation (as outlined above) supports or invalidates these theoretical models, examining both the ToC for clients of the IPS service and the ToC for the treatment services. Based on this assessment, we revised both ToC models and indicated elements not yet validated by this evaluation (Figure 8, Figure 10).

Revisions to and comments on the ToC for clients of the IPS service

This section will present comments on the inputs and activities of the ToC, followed by reflections on the outcomes and impacts. Figure 8 in the Annexes presents a revised version of the ToC incorporating these comments and reflections.

**Keyworkers’ willingness to refer clients to the IPS service is equally important as their knowledge of how to refer**

Both ToC models emphasise that trained and experienced IPS specialists, as well as additional support to treatment providers, are necessary ingredients (inputs) for a successful IPS service. This aligns well with our findings (section 4.1). Similarly, the collaboration between IPS specialists and treatment services teams (activity) was a critical mechanism to
address potential reservations of the latter and to help generate referrals and to facilitate a wider culture change (section 4.5.5).

The ToC model, however, did not adequately capture the implicit and informal criteria some treatment workers used when deciding whether to refer their clients to the IPS-AD trial. Some keyworkers continued to make informal judgements about whether clients were ‘ready’ to look for a job during the initial stage of the trial, but the evaluation findings show a lessening of this practice once the implementation of IPS matured (sections 4.1.5 and 4.8). The ToC model should be clearer in that the readiness of keyworkers to refer clients to the IPS service is equally important as their knowledge of how to do it.

The support provided to clients by TSKs, family and friends as others is an important input to be added

The ToC for the clients of the IPS service assumes that by integrating employment support and treatment, the complex needs of service users are addressed better and in a more coordinated manner. The importance of support from local treatment services and treatment keyworkers is included as a key input in the ToC model. This is evidenced in the evaluation findings, especially in how ES and treatment staff work together and support their clients in looking for and maintaining a job (section 4.2.2). We also note, however, that the assertive engagement and outreach by integrated (treatment and IPS) teams scored low in the fidelity reviews across most sites (section 4.8.1). We expect that when the IPS services mature further, even more evidence could be supplied on how clients’ complex needs are addressed better and in a coordinated manner, providing a stronger validation (or challenge) to the ToC model for the clients of the IPS service.

The ToC for the clients of the IPS service clearly marks the importance of the initial appointment with an IPS specialist when vocational profiling begins (activity). The complexity of IPS activities unfolds from that point and this has been substantiated by our findings (section 4.2.1). Some activities, however, such as vocational profiling and rapid job searches, seem to be more common than others included in the ToC such as appraising other needs and onward referrals. This is further highlighted by the low scores across most sites for follow-along support for clients’ individual needs. Such support might include support from mental health professionals, family and friends (section 4.8.1). The ToC model for the clients of the IPS service should be clearer in that support to the service users is provided not just by the IPS specialist but also by others, including treatment keyworkers, mental health support, clinicians, family and friends, and co-workers.

Some activities have not yet been evidenced in this process evaluation

The ToC for the clients of the IPS service also indicated that advice on disclosure (activity) is a key element of the IPS service and followed by responsive in-work support (activity) for both the employee and employer. This has not been evidenced by the process evaluation. The evaluation findings show that employer engagement was an area where challenges were found, and more progress was still needed (and expected) across most sites (section 4.2.5 and 4.8.1).

Findings validated the importance of improved confidence and increased motivation

The ToC for the clients of the IPS service noted improved confidence and increased motivation as expected outputs that were validated by the evaluation findings (section 4.3, 4.4.1 and 4.7.3). Similarly, the findings point to clients understanding better when work was
feasible and financially viable (output) through overcoming their fear about losing benefits (section 4.4.1); and to clients appreciating previous work experience (section 4.3.2), which indicates improved understanding of their skills/assets (output).

The evaluation findings, however, did not validate the importance of other expected outputs such as improved personal and social functioning, self-efficacy in job searches and knowledge of the labour market. This does not mean that these outputs are not important on the clients’ journey to finding employment, only that these were not yet captured in this evaluation.

The findings from the process evaluation are limited in terms of how they can be used to reflect upon the outcomes and impacts in the ToCs. This is largely due to the fact that the clients interviewed for the evaluation were still supported by the IPS service and that only a small number of them already found a job.

**However, most of the anticipated outcomes and impacts are yet to be validated**

The evaluation findings validated some of the anticipated outcomes – clients making job applications, attending interviews, and some of them receiving and accepting job offers (sections 4.2 and 4.4.1). Anecdotal evidence also pointed to remission from alcohol and drug dependence (section 4.4.1). The confidence, however, and willingness of employers to support people with alcohol and drug dependence is an expected outcome of the ToC that has not yet been validated in the process evaluation.

The process evaluation findings did not provide insights on employer- and client-related long-term impacts. Such impacts need time to materialise and to capture them, a different design (for example, longitudinal study) or a different sample of IPS participants (who completed IPS several months earlier) would be required. Insights of this kind may be provided by the parallel impact evaluation carried out by PHE.

Revisions to and comments on the ToC for treatment services implementing the IPS-AD trial

This section will present comments on the inputs and activities of the ToC, followed by reflections on the outcomes and impacts. Figure 8 and Figure 10 in the Annexes presents a revised version of the ToC incorporating these comments and reflections.

**The evaluation findings validated the importance of a number of activities and inputs**

As noted above, this ToC model underlines experienced and trained IPS specialists, as well as additional support to treatment providers, as necessary inputs to a successful IPS service.

The evaluation findings validated the importance of a number of activities outlined in the ToC model. These include engagement (or integration) between treatment services staff and IPS specialists (sections 4.1.5 and 4.6.2), and feedback about clients’ outcomes to treatment staff (activity) to secure their engagement and convince them about the value of the IPS service. This is evidenced in the evaluation findings, especially with regards the power of good stories (section 4.1.5). The findings showed that only a few organisational adjustments (activity) were needed to implement the IPS service (section 4.8), but some local challenges were present (section 4.1.1).

**The evaluation findings validated some outputs but did not find evidence to support others**

In terms of outputs, the ToC model did not adequately capture the discretion applied initially by some treatment workers when deciding whether their clients are ‘work-ready’
and whether to refer them to the IPS-AD trial (sections 4.1.5 and 4.8). The ToC model for local treatment services implementing the IPS-AD trial should be clearer in that the readiness of keyworkers to refer clients to the IPS service is equally important as their knowledge of how to do it.

Among other outputs, the findings confirm the importance of supervision in the IPS service (section 4.8.1), developing relationships between IPS specialists and treatment teams and building confidence among treatment professionals about the value of the IPS service (sections 4.1.5 and 4.6.2). The evaluation provided more limited validation for other expected outputs, such as developing relationships between IPS specialists and JCP staff (section 4.6.4).

The evaluation did not find evidence to support a number of expected outputs. These included that IPS specialists would share relationships and knowledge of employment services with treatment professionals, and those would develop their own relations with employment services. While there was also limited evidence of treatment professionals having meaningful conversations about work with clients or including specific employment recommendations and steps in the treatment plans, the evaluation findings point to a change in how treatment staff thought about employment (section 4.6.3). This hints at the existence of certain higher-level outcomes that were anticipated in the ToC model. These outcomes include treatment professionals making more regular use of referrals to employment services, better understanding relationships between health and work, recognising the therapeutic role of work and viewing work conversations as part of their role. It should be noted, however, that this evaluation did not validate these anticipated outcomes. Again, this does not mean that these outcomes are not important in achieving better integration of IPS employment support in treatment services, only that these were not captured in this evaluation.

4.9.2. Mechanisms and contexts in the IPS-AD trial: what makes IPS work

The analysis presented below draws on a targeted literature review of academic articles on IPS interventions,685 which was carried out as part of the evaluation of the Innovation Fund Health-led Trials.686 The review aimed to map key elements of IPS interventions and links between these elements in order to identify possible pathways to change, while keeping the employment as the primary outcome of interest. In this section, we examine the findings of that review through the lens of realistic evaluation and adapt these to the context of IPS in treatment dependence.

IPS in the mental health settings is well evidenced through multiple RCTs.687 These show that it is effective ‘across a variety of settings and economic conditions and is more than twice as likely to lead to competitive employment when compared with traditional vocational rehabilitation’.688 We also know that services that closely replicate the core principles of IPS will achieve positive outcomes. The core principles of IPS are reflected in the IPS fidelity scale which has good psychometric properties,689 including predictive validity (meaning that the higher the IPS fidelity, the better the outcomes).690

Despite this, less is known on what exactly it is about IPS that makes it work. There is a variability among IPS participants and not all of them find employment. This suggests that there might be some regularities (or patterns) which make the service work for some people and/or under certain conditions, and that those patterns remain hidden. This knowledge deficiency applies equally to IPS in both mental health services, and in the
alcohol and drug dependence context. While the effectiveness of IPS for people with alcohol and drug dependence is yet to be tested by PHE in the impact evaluation of the IPS-AD trial, this process evaluation draws upon realist principles and aims to capture the combination of factors that seem to make this service work. Drawing on Pawson and Tilley’s realistic evaluation our aim is to understand:

1. What mechanism(s) for change are triggered by IPS and how they counteract the existing social processes in place. We also, however, bear in mind that the mechanisms do not work on their own: they are triggered by specific conditions.

2. What social and cultural conditions are necessary for the mechanisms to operate and how they are distributed within and between service context(s).

We begin with mechanisms identified by analysing IPS principles and relevant IPS literature. IPS mechanisms should:

i. Reflect the embeddedness of IPS in the multi-layered, multilateral character of alcohol and drug dependence treatment services, which are provided by a network of NHS and voluntary sector community treatment services spread across different local authority areas.

ii. Explain how both macro (at the treatment services level) and micro (at the client level) processes establish the IPS service.

iii. Demonstrate how IPS outputs (including improved confidence, improved understanding of own skills/assets and career goals, improved self-confidence in job search) follow from the stakeholders’ choices (reasoning) and their capacity (resources) to put these into practice.

Below, we outline the mechanisms that could be discerned from the literature, our analysis of the IPS principles, and draw on our analysis of all data collected and considered.

**Macro mechanisms address the capability of treatment clients to secure competitive employment**

Here, we group mechanisms (M) that address the capability of treatment clients to secure competitive employment — in other words, those that might provide clients with necessary resources:

M1  **The ‘work first’ mechanism**: Finding a right job takes priority (and takes more time and effort) over training, upskilling or reskilling. It does not depend on a successful completion of treatment, or securing initial employment in a safe, sheltered setting.

M2  **The ‘integrated support’ mechanism**: People with alcohol and drug dependence have complex needs. By integrating employment support and treatment, these needs can be addressed better and faster, in a coordinated manner and in parallel with each other.

M3  **The ‘transaction’ mechanism**: The service is not mandated, and it represents a transaction between the ES and the client. The ES provides support and encourages the client to take up small, achievable tasks, thereby empowering the client to search for a job and take up employment. The path to employment is co-designed with the ES and forms a shared responsibility.

M4  **The ‘routine and interactions’ mechanism**: Clients engage in various activities (visit different work settings and talking to employers, meeting the ES at a local café or community centre) which affect the way they spend a day. This helps the client to establish
a rhythm of activity (meaningful occupations) and rest, and to make social interactions.696

**Micro mechanisms address the choices that treatment clients make**

Here, we group mechanisms (m) that address the choices that treatment clients make – in other words, those that might affect the way clients think and reason:

**m1 The ‘fostering motivation and confidence’ mechanism:** Some people with alcohol and drug dependence may accede to the culture of low expectations towards their chances of finding employment and, in the absence of the support and encouragement they need, they give up applying for jobs.698 IPS is open to clients who want to work. Yet, the motivation can be low at the start and it may fluctuate over time. ESs use motivational interviewing to maintain motivation and increase during IPS participation699 and build client confidence in finding a job. By recognising that their ES, treatment staff and family members believe in their capability, the client starts believing in themselves too.

**m2 The ‘can do work’ mechanism:** Some clients are concerned about their ability to work due to alcohol and drug dependence. For this reason, it is important that clients receive an individually targeted vocational intervention alongside treatment, their perceived work ability improves.700

**m3 The ‘walk-the-talk’ mechanism:** Job search starts within 30 days to keep up the momentum and to demonstrate the commitment of the ES to the client. The client realises that this employment support really is about finding a job quickly, rather than in a distant and unlikely future. This may initially put off some clients, while it may give others hope.

**m4 The ‘benefit calculation’ mechanism:** Some clients with alcohol and drug dependence may fear that trying to get a job will leave them worse off financially.701 Benefit advice helps address their concerns about losing benefits and being financially worse off after taking up a job, and can eliminate a major reason for not seeking employment.

**m5 The ‘discussing disclosure’ mechanism:** Clients with alcohol and drug dependence are reluctant to share information about their alcohol and drug dependence, mental health, or past criminal convictions to employers as they fear discrimination. Clients often lack certainty about whether, why, when and how to disclose this information when considering returning to work.702 ESs discuss this with their clients allowing them to make informed decisions in this area.

**m6 The ‘dream job’ mechanism:** Job offers are aligned with client’s preferences as ES work these out with a client from the start of their participation in the service. The client wants to take up the
job because they are interested in or passionate about it. The relationships developed by ES with employers allows ES to negotiate better or more suitable conditions for their client making the job offer even more desirable to them.

**Contexts set by social rules, norms, values or interrelationships, may trigger or stop the intended mechanism(s) of change**

We now move on to consider the contexts (C) within which mechanisms can be applied. Contextual conditions, set by the prior set of social rules, norms, values or interrelationships, may enable or disable the intended mechanism(s) of change so they form an integral part of the realistic explanation. Below, we outline the contexts that are established in the literature, identified in our analysis of the IPS principles and draw from our analysis of all data collected and considered:

C1 **The ‘treatment staff onboard’ context:** Some treatment staff may hold low expectations towards employment of people with alcohol and drug dependence and do not talk to their clients about employment support. ESs work closely with treatment staff to change this perception – a mechanism for a culture change in local treatment services implementing IPS.

• Resulting context: **Treatment staff see the positive effects of helping clients to return to work and encourage clients to consider working and to engage with the service.**

C2 **The ‘jobs are there’ context:** There might be a high unemployment or difficult economic situation in the area where IPS is implemented, which would limit employment opportunities available on the labour market. Also, some employers may underestimate the skills, experience and capabilities of people with alcohol and drug dependence or be reluctant to recruit them due to fears about their reliability, costs of support needed, impact on existing staff, or on the reputation of the business. ESs develop and maintain relationships with employers to identify and better understand their recruitment needs, address employers’ reservations, and suggest a suitable candidate from among their clients – a mechanism to facilitate a change in the employer’s attitude and behaviour.

• Resulting context: **There are jobs to be found or carved out with employers for people with alcohol and drug dependence.**

C3 **The ‘work pays’ context:** Some clients do not take up employment for the fear of losing either benefits or ‘cash-in-hand’ jobs they may already have to get by.

• Resulting context: The benefit calculation shows that work is a financially viable option and that the client would be better off financially in competitive and legal employment.

C4 **The ‘family support’ context:** Some clients perform unpaid work in the household (for example, take on childcaring responsibilities) that other family members are keen for them to continue doing (rather than take up a job). Some family members may hold low expectations of the client’s chances to get a job. ESs may need to work with the family to eliminate barriers to employment – a mechanism to remove obstacles or trigger support from the family.
• Resulting context: The family supports or does not hold back the client in taking up employment.

C5  The ‘neutral territory’ context
Some substance users do not trust mainstream employment support providers, others (including those who were mandated to alcohol and drug dependence treatment via the criminal justice system) may distrust the treatment services. ESs offer their services, engagement and outreach in the community to help normalise the IPS specialist–client relationship and to quicken the development of client’s trust and openness – a mechanism to build a relationship between ES and the client.787

• Resulting context: The employment support is provided in a neutral or trusted territory.

In this section the ToC models were critically reviewed and subsequently revised clearly outlining the areas where evidence is still lacking. Drawing upon realist principles, this analysis spells out the mechanisms and contexts – the combination of which could explain what makes IPS work.
Chapter 5. Conclusions and implications for the future

This section summarises the main findings and draws general conclusions from the evidence gathered in the process evaluation (section 5.1). It also focuses on the implications of these findings for policy and practice if and when establishing IPS in drug and alcohol treatment services (section 5.2). The section then outlines the contribution of the evaluation to the evidence on IPS (section 5.3) and the implications for future research (section 5.4).

5.1. Overall findings and conclusions from the process evaluation

5.1.1. Implementing IPS in the specific context of treatment for alcohol and drug dependence: barriers, facilitators, and organisational processes for IPS

Finding 1: IPS has been implemented successfully in seven alcohol and drug dependence treatment services, which represent diverse contexts and organisational settings

Our findings show no structural or systematic issues with IPS implementation in the context of treatment services, regardless of their organisational settings, socio-economic situation, or proportions of clients in treatment. All seven sites implemented IPS, improved service quality over time and achieved good or fair IPS fidelity scores. Across almost all sites, the most challenging elements of IPS to implement adequately were job development, follow along supports, community-based services and assertive engagement and outreach. These challenges are not unique to implementing IPS in the context of alcohol and drug dependence treatment services. Even the most challenging fidelity review items had been implemented well by at least one of the trial sites, making it possible for sites to share experiences and learn from each other. All trial sites increased fidelity review scores over time, which demonstrates a capacity for quality improvement for IPS-AD.

Across all sites, all interviewed stakeholders agreed that the IPS principles were easily applied in the context of treatment services. There was wide support for the IPS services across all sites and different stakeholder groups. Yet, cost considerations played an important role for the commissioners when considering whether and how any future IPS services could be implemented.

We conclude that IPS-AD could be successfully implemented more broadly across treatment dependence services, providing that (i) the service proves to be effective and that (ii) funding for the service is available.

Finding 2: Location-specific factors had an impact on IPS implementation across most sites and had to be worked through on a case-by-case basis

Our findings illustrate that local barriers and facilitators have impact on IPS implementation and almost all sites reported some unique factors that affected them. Services that were provided in geographically dispersed sites (Staffordshire, Derbyshire) struggled to integrate IPS with all treatment services teams and to share learning within the IPS team. This was due to the large distances between ESs
who were placed in different treatment centres. Similarly, the nature of the local economy and the number and distribution of jobs was reported as a strength for some sites (such as the urban centres of Sheffield and Birmingham), but a challenge for others (such as competition for entry-level jobs in Brighton, and the rural nature of some areas of Derbyshire).

Of these factors, large distances between treatment centres in a few sites seem to be a particularly important challenge to IPS implementation due to their multiple implications for: ESs (sharing experiences and job opportunities, IPS supervision), clients (commuting for appointments, job interviews and work), and treatment staff (learning between keyworkers). We note, however, that these challenges have been either effectively addressed or mitigated by the sites hosting the IPS-AD trial.

‣ We conclude that IPS implementation is linked with some challenges specific to geographical situation and the organisational set-up of treatment services. As with any social intervention, for IPS to work, it needs to be well embedded in the unique settings in which treatment services operate. Some of these hurdles can be anticipated and mitigated against early on during implementation. Other hurdles may materialise only during implementation. The experiences of the trial sites can provide a useful basis for others to learn how such difficulties could be dealt with or overcome.

Finding 3: Recruitment, development and retention of IPS workforce was key for successful implementation

Our findings demonstrate that having ESs with the right skills and backgrounds who could build personal relationships with keyworkers and clients were viewed as strong enabling factors of IPS implementation across all sites and all stakeholder groups. The two sites that experienced issues with IPS staffing (Haringey struggled with recruiting ES, Birmingham experienced high staff turnover) often resulted in the IPS team being short-staffed, which then contributed to their lower scores in fidelity reviews.

Our findings show that in most trial sites, the IPS-AD workforce comprised two profiles: (i) professionals with experience in supporting people with alcohol and drug dependence, but who had more limited practice in employment support; and (ii) professionals who brought experience in employment support for vulnerable groups, but not necessarily in the treatment service context. According to many interviewees representing different groups of stakeholders, it was important to have both sets of skills and experiences within an IPS team to ensure the successful implementation of IPS in a site. This was also recognised by PHE, IPS services at all sites, and all treatment services, all of whom commissioned or provided relevant training opportunities for ESs.

Training opportunities for ES were considered helpful by most participants across all sites. The initial in-person IPS training provided by the CMH stood out as particularly helpful, as it brought all recruited ESs together and onto the same page at the start of the trial. Ensuing training sessions on employer engagement organised by PHE, and PHE away days that focused on several challenges faced by the sites during the implementation, were viewed by the majority of ESs across all sites as even more useful and appropriate. Similarly, individual treatment services provided a number of ES training opportunities focusing on the needs of the client group and these were reportedly beneficial to many interviewees. Such opportunities facilitated professional development and mutual learning among ESs,
thus helping improve the consistency and quality of IPS implementation across all sites.

- We conclude that successful recruitment of ESs is a prerequisite for effective IPS implementation. ESs do not necessarily need to have all the relevant skills and experience upon starting in the role, but need to be suitably flexible and willing to learn. ESs also need to receive training and development opportunities to ensure that this knowledge and experience is deliberately fostered. Professional development of ESs on both aspects of their role (IPS and working with the clients of community drug and alcohol dependence treatment services) is essential to ensure that ESs from a range of backgrounds understand the employability demands of their jobs, the needs and characteristics of their clients, and the culture and processes of their treatment services. This is especially important if ESs join from another sector without prior experience of working with this client group.

Finding 4: IPS teams became more integrated and embedded in treatment services over time, with several factors supporting the process

Our findings show that factors that helped the integration of the IPS team into the treatment services in each of the trial sites included co-location and good communication between IPS and treatment services workers. These factors helped develop personal relationships between ESs, treatment staff and clients, which many interviewees (from across sites and groups) considered to be an important enabler. This was emphasised particularly by the sites where some treatment service teams did not have a permanent ES on-site (Haringey, Derbyshire, Staffordshire). Where integration was less strong, this tended to be because either co-location had not been consistent or there had been changes in the IPS personnel (for example, Haringey, Birmingham). Securing support from treatment services management and commitment from treatment staff was another necessary condition for the full integration of IPS in treatment services, which was identified across all sites by many interviewed stakeholders.

- We conclude that integration of IPS with treatment is one of the core principles of IPS that applies to and can be successfully achieved in the specific context of alcohol and drug dependence treatment. Effective integration can be achieved through ESs being formally employed by the same body as treatment services teams, ESs being co-located with treatment colleagues, and through having processes in place that enable ESs to attend team meetings, access case management systems, and work together. Integration also encompasses informal aspects of work, such as ESs frequently keeping in touch, sharing updates and good news stories with treatment services staff.

Finding 5: There has been wider change in the way some treatment staff in the trial sites think about the role of employment in dependence treatment and how this may be altering their practice

Integration of IPS into treatment teams is designed to bring about a change in culture to ensure that treatment teams view employment as a viable option for their clients and as a means to help with clients’ recovery. Our findings indicate that across all sites treatment services staff were (increasingly) keen about IPS thanks to multiple engaging strategies employed by ESs (including attending joint meetings, using good news stories, building personal relations, securing management support).
Many interviewees across different stakeholder groups also felt that the presence of ESs, their use of strategies to engage treatment services staff, and the IPS-AD trial more generally were making treatment services culture more conducive to conversations about employment for their clients. This had some impact on the employment-related knowledge of treatment services staff.

It is, however, less evident whether this favourable environment and raised awareness of the role of work in treatment translated into different practice across all treatment services hosting the trial. While some interviewees thought that the way treatment staff work with their clients was shifting (with, for example, more conversations about work initiated by some keyworkers), others were unsure about whether there were more substantial changes in the actions and practice of treatment services staff.

‣ We conclude that the IPS-AD trial laid the conditions for wider cultural change in how alcohol and drug dependence treatment teams view employment as part of recovery, but also that this is a long-term impact which may require more time and effort to materialise.

Finding 6: Securing referrals and keeping the clients engaged was a continuous effort

This study establishes that referrals of clients to IPS became easier to achieve throughout the course of the trial in all sites, and that this was a result of improved integration and ongoing strategies and work by ESs and TSMs.

Ongoing barriers to referrals included keyworkers’ use of discretion when deciding whether or not to refer a client, although the number of treatment services staff who continued to use discretion in deciding who to refer was declining across all sites towards the end of the trial. The IPS teams used various strategies to ensure a steady stream of referrals to the service (including taking time to explain the trial to keyworkers, sharing stories of clients’ progress on the IPS-AD trial and simplifying referral processes for keyworkers) and reported that these had to be maintained throughout the trial’s lifetime to ensure that referrals remained consistent. Enabling factors included having simple processes for referrals and ensuring the co-location of the IPS team in treatment services.

Client disengagement with IPS was another common difficulty faced by some trial sites and noted by many stakeholders in sites hosting the trial. There was no clear reason why some clients did not engage with the service, with some interviewees reporting lack of or fluctuating motivation, and with other clients cutting contact without giving any reasons. ESs used a number of re-engagement strategies to try and tackle the low rates, including making email or phone contacts, organising joint meetings and assertive outreach attempts in collaboration with keyworkers, and making informed judgements of when to ease up and pause reaching out to clients. In one site (Derbyshire), this was supplemented by the use of behavioural psychology insights about how to encourage engagement.

‣ We conclude that continuous efforts are required from ES and treatment staff to:
  (i) identify treatment clients who want to work, and (ii) keep them engaged with IPS.

‣ For a client with a mental health condition, lack of engagement could indicate that a client’s mental health had deteriorated and that they might benefit from additional clinical support. This situation would require follow-up from a member of the integrated IPS team. In the context of alcohol and drug dependence, client disengagement is more difficult to interpret and immediate follow-up may
not always be appropriate. Until reasons for the lack of engagement among different groups of clients are better known, ESs may have to rely on using their discretion in deciding when, how often and how long to follow up with non-engaging clients.

- Similarly, until evidence for effective engagement strategies is established, ESs may need to draw on existing practices established in traditional IPS\textsuperscript{709} developed by the seven sites hosting the IPS-AD trial, or to test new methods.

5.1.2. Delivering IPS to clients with alcohol and drug dependence

Finding 7: Treatment clients have different levels of confidence about finding employment, different levels of motivation, mixed prior work experiences and personal circumstances

Our findings show that clients had varied levels of confidence around finding employment in each of the trial sites. Individuals’ feelings about finding employment very much depended on many personal factors and their motivation could fluctuate considerably over time. Some common themes, however, did emerge in terms of concerns around returning to work. These included the potential impact this might have on receiving benefits, on health and on possible relapse and having long periods of unemployment on their CVs. Common themes were also present in terms of the incentives to work, including having a better income and an activity to reduce the time and opportunity for substance use, a chance to meet people and to ‘repay’ society.

The barriers to work commonly described by clients, ESs and keyworkers were linked to clients’ individual circumstances, fears and difficulties. They included a lack of motivation and/or low self-esteem, poor physical or mental health, an insecure housing situation, having a criminal record, a lack of relevant skills, experience or qualifications, and nervousness about starting a new job. Among the facilitators associated with finding employment, the attitudes of ESs and treatment services staff seem to play an important role: some clients were motivated and encouraged by their ES’s and keyworkers’ belief in their ability to find and keep a job. Other enablers include confidence building, access to training and introduction to work through an intermediary.

Our findings show that in the seven trial sites, many clients felt that support from JCP had not been helpful for them. Sometimes this was explained in terms of the support received being insufficiently detailed, and JCP work coaches not having sufficient knowledge of supporting clients with drug and alcohol dependencies. Many interviewed clients reported considerable mistrust of and dislike towards the JCP. Most interviewed clients also reported that prior to the IPS-AD trial, they had had little help with employment from their treatment keyworkers.

- We conclude that with such a diversity in the client group, where a standard and uniform approach to employment support may be failing, a complex, flexible and individual approach – such as IPS – is particularly well suited to address diverse and complex needs of clients in treatment for alcohol and drug dependence.

Finding 8: ESs built a rapport with clients and provided them with IPS support that was widely valued

Our findings demonstrate the importance of the relationships between clients and their ES. To build supportive relationships, ESs used active listening to understand the client’s situation, empathy and motivational interviewing. We have shown that the first IPS
appointment was a basis upon which ESs built their support for the client. The activities of job-seeking followed a pattern of vocational profiling, completing a CV and putting in applications for jobs. ESs aimed to raise or maintain clients’ motivation and expectations of finding work, and to build up their confidence in their abilities. IPS helped clients by its quick focus on job search activities, the flexible and personal support provided by ESs, and by the way in which it focussed on clients’ preferences and ambitions when finding possible jobs.

Our findings show that strong motivation to work and stability in clients’ recovery were the key factors that affected how engaged clients were with IPS. We also find that, according to a number of interviewees, stability in other areas of life made it easier for clients to benefit from IPS, but that other factors, which may predict when IPS is most beneficial are difficult to identify. Evidence from the Black review, however, demonstrates a number of common predictors of employment for people receiving support from substance use treatment services which may be predictors for successful IPS outcomes (for example, gender, age, physical or psychological health condition, length of time of substance use, level of deprivation in the area).

According to many interviewed clients across all seven sites, IPS was a personal, accessible and flexible service in which clients felt understood by their ES. Some clients in many trial sites reported that IPS had improved their life by indirectly helping with family relationships, reducing their drug use, and giving them hope for the future. A few clients suggested that their experience with IPS would have been even better if contacts with ESs had been more frequent, more regular, and been available to access for longer, and if ESs provided better links with employers.

- We conclude that IPS delivery in drug and alcohol services is an individual approach, drawing out skills which the client may not have considered they own, and helping them to present a good case for their ability to work in CVs and application forms. Feedback about the IPS service received was overwhelmingly positive and many clients felt that IPS had been helpful for them, even if they had not yet found a job. The impact evaluation may provide further (and stronger) evidence on participants’ characteristics associated with the likelihood of finding a job as a result of IPS.

Finding 9: Low levels of disclosure of alcohol and drug dependence to employers formed a barrier to some aspects of the ES role

In this evaluation, we use the term ‘disclosure’ when we report on findings from interviews and fidelity reviews and to explore how ESs supported clients in their decisions about whether or not, to what extent and how, to inform potential employers about their substance use history. We recognise, however, the shift in IPS practice towards ESs having more wide-ranging conversations with clients about how they wish to present their past experiences, diagnoses, treatments and other personal information to potential employees and other people, and the potential benefits this can bring.

Our findings send a strong signal about the challenges faced by ESs across all trial sites due to clients’ reluctance to disclose their alcohol and drug dependence to employers. Many clients were reluctant to disclose their condition to potential employers, thus limiting ESs’ ability to engage with employers or to provide in-work support, particularly to the employer or the client and the employer together. We show that many ESs had to
develop strategies to address this issue (for example, agreeing to talk in terms of mental health conditions rather than alcohol and drug dependence), due to a perceived stronger stigma surrounding the latter. This was particularly difficult for the sites where ESs were employed by specialised treatment providers (for example, Derbyshire, Staffordshire) and where the name of their employer disclosed the group of clients they work with. In the absence of client’s agreement to disclose, those IPS teams had to come up with innovative ways in which they presented themselves and their clients to potential employers (for example, by legitimate rebranding as one of their partner organisations, such as the NHS trust or a local council).

The evidence on disclosure collected in this study focuses on the IPS-AD trial and does not provide direct comparisons with IPS for people with severe mental illnesses. Our findings, however, point to a possibility that these aspects of IPS (employer engagement and in-work support) may be more difficult in the context of treatment for alcohol and drug dependence.

Whether, to what extent, and how to tell a potential employer about substance use or treatment history should always be a fully informed choice made by the client. We recognise the importance of ongoing and wide-ranging discussions with all clients about the implications of disclosing and not disclosing substance use and treatment history. We also acknowledge gaps in the current evidence, in particular in relation to: (i) attitudes and behaviours of employers towards recruiting and supporting people with alcohol and drug dependence; (ii) effects of disclosing (or not disclosing) substance on prospects of finding a job, and on work experiences for people with alcohol and drug dependence.

We conclude that due to challenges surrounding disclosure, the implementation of IPS-AD may be particularly challenging in specific settings where IPS teams have more limited options to represent their clients without disclosing the nature of their condition. As such, future IPS teams should consider their branding to avoid reference to substance misuse, if possible. The experiences, however, of the trial sites show that this can be overcome through collaboration and partnership working. We further conclude that full implications of the lack of disclosure, especially on employment outcomes are not well evidenced.

Finding 10: Employer engagement and support remained one of the most challenging aspect of IPS-AD

Notwithstanding issues of disclosure discussed above, our findings show that most ESs across all sites found it difficult to carry out the aspects of IPS that involve approaching employers, brokering paid work and offering in-work support to both clients and employers. Over time and with additional training (see Finding 3), good practice around employer engagement started to emerge in many sites hosting the trial (for example, emphasising the ways in which ESs can support the employer during initial conversations with employers). Many ESs, however, continued to struggle with some aspects of this work, especially job carving. Some ongoing challenges include employers’ reluctance to engage, as reported by a number of ESs, and strategies to address this were used throughout the trial.

We also note that the process evaluation conducted very few interviews with employers, with the main challenges in securing these interviews related to the limited number of employers who could be contacted by the
evaluation team. The evidence collected is insufficient to draw firm conclusions on the attitudes and behaviours of employers who engaged with IPS or on their views on and experiences with the service.

‣ We conclude that there are three main factors affecting the low levels of employer engagement in IPS-AD:

• Most clients and ESs fear the stigma on the side of employers, which stops them from hiring people with alcohol and drug dependence, partially as a response to this fear
• Clients are reluctant to tell potential employers about their alcohol and drug dependence which limits the role that ESs can play (see Finding 9)
• ESs felt they lacked know-how, experience and confidence in employer engagement and job development

‣ There is a need to better understand clients’ reluctance to disclose their alcohol and drug dependence and employers’ concerns round hiring people with a history of alcohol and drug dependence. This includes concerns around those using specific substance uses. There is also a need to consider other ways in which these concerns can be addressed.

5.2. Implications for policy and practice: establishing IPS in drug and alcohol treatment services

Below we present recommendations about how IPS might be implemented in a drug and alcohol treatment services context in the future – providing that it is found to have a positive effect on outcomes and is recommended for further rollout. To make our recommendations as useful as possible, we distinguish between those relevant to ‘future funders’ (including PHE, DWP, other central or regional institutions and bodies that may provide resources for IPS in the drug and alcohol context in the future) and to ‘future implementers’ (comprising treatment services that may implement IPS-AD in the future, including treatment staff, local commissioners and future ESs).

As a tried and tested model, we are aware of the extensive literature and evidence around how IPS should be implemented, demonstrated most notably through the creation of the IPS fidelity scale. These recommendations are designed to act as supplementary considerations rather than as an alternative to this model around how implementation might work for this specific client group and in the context of drug and alcohol treatment services.

Recommendations for future funders

1. If IPS-AD proves effective, this process evaluation provides supporting evidence to support a wider roll-out and implementation of the service for people with alcohol and drug dependence. Future funders should provide the necessary resources that allow for:

(i) the preparations for the set-up of IPS in the treatment services; (ii) early implementation of the service and any necessary adjustments due to specific local challenges; (iii) full implementation of IPS; and (iv) continuous professional development of the IPS workforce, both in terms of their expertise in IPS and in working with clients with treatment dependence. In particular, this relates to those aspects of ESs roles that proved most difficult (for example, employer engagement, individual follow-along support, active engagement and outreach).

If funding is made available, future funders should consider including employment outcomes as service key performance
indicators, to further incentivise the recovery services to work towards employment for people with alcohol and drug dependence who would like to be in work.

2. Future funders should also provide resources to enable wider learning and service quality improvements. This involves securing funding for regular fidelity reviews of individual IPS services, as well as for sharing experiences across a wider community of treatment providers implementing the IPS service. We recognise some unique aspects and challenges of IPS implementation in community drug and alcohol treatment and recommend that future funders support a network of IPS teams working in treatment services to allow for mutual support and learning between sites. The IPS Grow model (which operates in England and supports widening access to IPS for people with severe mental illness) provides a blueprint for similar efforts. Rather than creating a parallel scheme, we recommend that future funders consider the possibilities of joining forces and pooling resources to enable wider learning across the country and services (that is, between the mental health and alcohol and drug dependence treatment services).

3. The implementation of the IPS-AD trial initiated the process of accumulating experiences and good practices in setting up and implementing IPS in the context of treatment dependence services, many of which are captured in this report. Future funders, in collaboration with the seven trial sites, should consider developing practical material for treatment services planning to implement IPS in the future. This material could build on, complement or adapt existing resources, such as those offered by IPS Grow for example:

- Guidance on commissioning mental health and employment services
- Advice on how to set up an IPS service
- Briefing note on the procurement of IPS services and templates for IPS procurement
- Template specification for procurement of IPS services, service cost calculator, outcome targets calculator
- Briefing note or poster for clinicians to share the benefits of IPS.

4. Future funders, in collaboration with PHE and the seven trial sites, should further consider identifying, collating and disseminating: (i) examples of practices to engage clients with alcohol and drug dependence for future ESs; and (ii) client testimonies and good news stories to be shared with treatment staff and potential future clients. Building on the identification of barriers and enablers associated with finding employment outlined in this report, future funders could also develop (iii) marketing materials (in a form of frequently asked questions or myth busters) designed to inform treatment clients about IPS, address common concerns around returning to work, and outline the potential benefits of work and advantages of working with ESs. This may include client testimonies of their relationship with an ES and how the ES works with a client (focusing on the pragmatic, flexible and non-judgmental support highly valued by clients).

5. As highlighted in this evaluation, there are some aspects of IPS in community drug and alcohol treatment where further evidence is needed. One potential area where additional support from future funders may be needed relates to
understanding and addressing barriers to employment for people with alcohol and drug dependence that may exist among employers. Future funders should consider commissioning further research or evaluations in the areas outlined below (section 5.4).

**Recommendation for future implementers**

6. **Accounting for the local context:**
   Treatment services that wish to implement IPS should consider their organisational set-up and geographical contexts, identify close matching sites from among the seven services hosting the IPS-AD trial, and draw on practices and lessons from these IPS services. In planning for IPS implementation, treatment services staff should be kept involved and fully informed about the decision to launch an IPS service from the early stages. This might include running briefing sessions or workshops that could include presentations by IPS experts, funders, clients with alcohol and drug dependence who received IPS support and should emphasise ‘zero exclusion’ (in other words, eligibility for IPS for all clients who wish to work). TSMs and IPS team leaders should prioritise the integration of IPS workers from the start and make use of the ‘IPS Fidelity Manual’ and any additional material developed on the basis of the IPS-AD trial (see recommendations 3 and 4 as guidelines for what good integration should look like. If possible, ESs should be introduced to the treatment services before the IPS service formally launches, to allow ESs to establish themselves and to ensure that referrals can start strongly.

7. **Building a new IPS team:** Treatment services recruiting an IPS team should: (i) use existing material for IPS workforce (for example, competency framework, job descriptions); and (ii) build on this material to recruit a team of ES with a range of experiences and skills, including both those with employment support experience and those with experience in working with this or a similar client group. The range of such profiles should facilitate mutual learning within the team and address demands of delivering IPS in the context of services for treatment dependence. As noted above ESs, especially those newly recruited, must be given induction training and continuous development opportunities to both learn about the treatment services and the client group, and to strengthen their understanding and experience in IPS. The timing of any such training and development should be carefully considered to align with evolving needs of ESs and the pattern of implementing a new IPS service. This starts with securing referrals, before managing caseloads, engaging employers or providing in-work support. ESs should also draw on existing IPS resources, which support various aspects of the role: from referrals, vocational profiling, discussing how and when to share personal and health information, to engaging with employers. IPS team leaders must identify training and development needs for their teams through effective supervision, as recommended in the IPS Fidelity Manual. If required, they should also work with commissioners or funders to address these needs on an on-going basis.

8. **Integrating ES with treatment staff:** commissioners and treatment services senior management should demonstrate their commitment to and support for the IPS service by ensuring that ESs are embedded in the treatment services (in other words, that they are co-located, have access to case-management systems and take part in multidisciplinary teams).
TSMs or supervisors should discuss the IPS service regularly with keyworkers to encourage them to refer their clients to IPS. The IPS team leaders and ESs must also promote IPS and work towards achieving full integration with treatment teams. While turnover in IPS teams is sometimes unavoidable, to ensure that the integration of ESs and treatment services teams is not hampered new ESs should be recruited to begin before outgoing ESs leave the service wherever possible. This would ensure that there are sufficient lead-in periods and handover. IPS team leaders should also ensure that there is appropriate induction for new ESs and TSMs should also support ESs as full members of the integrated team.

9. Engaging treatment clients with IPS: ESs should make use of (or develop) marketing materials (see recommendation 4, which would highlight the elements of IPS support clients found most helpful (that it is personalised, flexible, supportive, and accessible). These materials might include case studies, client quotes or testimonies to promote the service to potential clients. ESs should expect that treatment clients may be facing multiple barriers to employment and experiencing motivation and confidence issues, as noted by this evaluation. As such, ESs should be well-equipped to deal with this – for example, by developing strong motivational interviewing skills (see recommendation 7) and drawing on materials available through IPS Grow, which may include:

- Referral form template (in case a written referral is required)
- Vocational profile that helps to explore and identify clients’ job goals
- Vocational action plan that sets out the steps needed to achieve the long-term job goal
- Job canvassing sheet that helps the client to track their job searching activity
- Information on managing personal information (including, for example, the pros and cons of sharing health and other personal information with an employer)
- Skills development template that allows ESs and clients to review progress regularly
- In-work support plan to give a job placement the best chance of success.

Given the nature of the client group, ESs may also expect a high rate of clients who do not attend meetings. Therefore, ESs should follow good practice in IPS by using the strategies and benchmarks that are provided by the IPS Fidelity Manual and outlined in this report to re-engage with clients. This may involve: (i) gathering data on disengagement (for example, when it occurs, how long it lasts, who it involves); (ii) working with treatment staff and clients to understand individuals’ reasons for disengaging; (iii) learning from treatment staff how they engage with clients to inform IPS practice; and (iv) testing different strategies to address disengagement and measure their success.

10. Implementing high fidelity IPS: The new IPS teams should follow good practice in IPS by using the strategies and benchmarks that are provided by the IPS Fidelity Manual and any additional material developed on the basis of the IPS-AD trial (see recommendations 3 and 4). Particular attention should be given to managing personal information, employer engagement and in-work support
for both clients and employers. Future implementers should ensure that ESs know how to, and have confidence to, engage employers. They should help ESs outline a broader range of possible forms, intensity and frequency of in-work support to clients, which may help them to support the clients in making more informed choices about any in-work support they would like. Future implementers should arrange for regular fidelity reviews of the services – these should apply to new and established services alike – in order to improve and then maintain the quality of the IPS service.

5.3. The contribution of the evaluation to the evidence base

The findings presented in this study contribute to the evidence on IPS and on employment support for people with alcohol and drug dependence in a number of ways:

1. The report provides findings from empirical research with a range of stakeholders working directly or indirectly with treatment service clients outlining their experiences, views and perceptions on supporting this group in their journey to work and recovery. Through three waves of interviews with commissioners, ESs, treatment staff and JCP representatives the study offers interesting insights into complex, often patchy, and evolving relationships between these actors.

2. This evaluation documents the process of launching and delivering the first large-scale, multi-site, definitive, superiority RCT of IPS for clients with alcohol and drug dependence. Our findings provide observations that could be useful for service delivery.

3. The report offers a wealth of qualitative data from empirical research with treatment clients. It presents their experiences, expectations, concerns and feedback on the employment support offer available for the treatment as usual group, as well as those engaging with the IPS service.

4. This evaluation draws on the theory-based approach and realist principles to: (i) develop and refine the ToC models that explain how IPS brings about the expected outcomes; and (ii) identify mechanisms and contexts that interplay with each other and explain the causal influences in IPS. These conceptual models, as well as the contexts, mechanisms and outcomes that have been identified here, can further support the work of treatment services that want to incorporate IPS in the services they offer, and that of future researchers and evaluators who are interested in supported employment and treatment for alcohol and drug dependence.

5.4. Implications for future research

Building on the contribution of this evaluation, we outline areas below where evidence is weak or missing, which future research should address:

1. When providing their perceptions and opinions, stakeholders participating in the evaluation did not identify specific characteristics that make it easier or more difficult for treatment clients to engage with IPS. Such knowledge may be better captured in the impact evaluation or examined in future research. Further research into the reasons why clients do not engage with the IPS services and the extent to which various strategies to address this are successful would be valuable and help to inform future delivery.
2. It may be particularly difficult for clients to tell employers about their alcohol and drug dependence or treatment history, due to the societal stigma associated with alcohol and drug dependence. Further research is needed to examine and compare which characteristics of this client group are stigmatised most among employers. This can then be used to develop and adopt strategies that can address employers’ stigma effectively, which will further facilitate the work of IPS services.

3. Further research is needed to investigate whether IPS clients with mental health conditions and/or alcohol and drug dependence who do not choose to share their alcohol and drug dependence or mental health condition with potential employers are more (or less) likely to gain paid work compared to those who chose to disclose. Such research should also examine the differences between these two groups in terms of sustainability of employment.

4. This evaluation sheds only limited light on in-work support for the clients and employers, the ideal length of IPS support, and the ways in which IPS support can be effectively brought to an end. Further research into the optimal length of IPS support for treatment clients would be helpful in developing future IPS models that aim to strike a balance between the (expected) benefits and costs of delivering the intervention.

5. Future evaluations should aim to validate (or disprove) the outstanding causal links identified in the ToC models around the long-term impact of IPS on the treatment clients and on practices in local treatment services implementing IPS. Future research should also consider ways in which the impact of IPS on the culture of treatment services can be measured. In addition, this report outlines the mechanisms and outcomes that may explain causal links in the IPS model. Future evaluations should be designed to collect data to test these different Context-Mechanisms-Outcomes pattern configurations in IPS services.

6. Many stakeholders in this evaluation perceived that clients who are at a stable point in their recovery journey and life (for example, with stable housing) may be more likely to benefit more from IPS support. Further research should investigate what kinds of wider interventions may contribute to supporting clients’ recovery from substance use and successful job seeking. This may include examining the impact of any ongoing housing interventions and programmes that provide individual physical health support to these client groups.

7. This evaluation identified some key skills and abilities that stakeholders considered important in being a successful ES. More research that examines which skills and abilities of IPS workers correlate with highest numbers of job outcomes for their clients would help in identifying these traits further and in the future recruitment and training of highly qualified staff.
References


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Annex A. **Further information about data collection**

**A.1. Targeted literature review**

The targeted review referenced in this evaluation has been carried out for DWP as part of the evaluation of the Health-Led Trial (IES (Institute for Employment Studies), n.d.). It was carried out to inform the design on the trial, and more specifically to identify IPS logic models, key elements of the trialled IPS interventions, and possible pathways which may lead to the intended outcomes.

Given the limited resources for this task and to limit duplication of work, RAND Europe (at the request of the DWP), conducted the review in collaboration with another ongoing DWP project – the RISE project, which involved conducting a systematic review and examination of specific components in an IPS-approach).

We requested the RISE project to share one or two articles included in their review per each of the 3 broad types of IPS interventions, namely those:

- Using a classic IPS fidelity model with a severe mental health population who are out of work
- Adapting the IPS model for another population (for example, affective/mood/bipolar disorders, substance abuse, homeless, spinal cord injury, musculoskeletal injury or traumatic brain injury)
- Drawing on the IPS approach more generally and augmenting it with another intervention/intervention component (for example, social skill training, cognitive training, neurocognitive enhancement therapy, supported education, cognitive behavioural therapy).

In total, nine articles were supplied by the RISE researchers. These provided a variety of IPS approaches which draw on somewhat different intervention logics.

To accommodate for a specific design feature of the health-led trial (for example, including non-traditional populations: workers at risk of losing a job, people with any health conditions), we also ran targeted searches to identify evidence on IPS for:

- Different sub-groups (for example, people with long vs short-term conditions, different age groups, people in work vs out of work)
- Different implementation settings (multiple vs single sites, large vs small scale).

We used defined search terms on Google Scholar and snowballed from identified articles. In total, 20 articles were included in the review.

**A.2. Interviews**

In all three Waves of interviews, the stakeholder interviews were arranged with the help of the PI (who also is the SES) from each site.

In Waves 2 and 3, in order to contact and arrange interviews with participants, we matched the data received from PHE (including the substance group and trial arm of participants) with the data received from each individual site (including the participant’s name, contact number and home address) using a unique identifier.
From this, we divided participants from each site into groups based on whether they were in the control arm or the intervention arm and based on their substance of use (alcohol, other drugs, and opioids). We randomly selected participants to contact. The majority of these participants were approached for interview by text message. The small minority for whom email addresses were provided were first contacted by email, and then by text message if there was no response.

If a client replied ‘yes’ to a text message asking them to take part in an interview or gave us a missed call, we would speak to them on the phone and arrange an interview time.

We developed topic guides for each stakeholder group in Wave 1 and each participant group in Wave 2. For each subsequent wave of interview, the evaluation team revised and adjusted the topic guides depending on reflections and feedback from their previous use.
Annex B. Theory of change assumptions

B.1. Individual-level ToC

The important element of the individual-level ToC is to explore the pathway which is likely to lead the client to engage in job search and find employment. It is difficult to distinguish between impacts, outcomes and outputs as some of them may belong to more than one category at the same time.

B.1.1. Inputs

Assumptions, unintended consequences, other points:

1. The referral sources are: (i) aware of the trial; (ii) aware of and understand the referral mechanisms in the trial; (iii) motivated to make use of the referral mechanisms; and (iv) able to conduct an element of screening of potential participants – in particular, of their health and employment status and their motivation to enter work

2. The integration of IPS specialists within AD treatment teams is important for the provision of co-ordinated support to participants

3. Potential participants are: (i) sufficiently motivated by the referral to attend the initial appointment; (ii) aware of and understand the information they receive about the trial and trust it sufficiently that they consent to take part in the trial; and (iii) sufficiently motivated after the initial appointment to attend a subsequent appointment with an IPS specialist

4. Services needed to address participants’ wider needs are available and accessible to them

5. Sufficient volumes of employers and jobs (that meet clients’ aspirations) exist and are open to recruitment through networking

6. There are jobs on the labour market that are available and match profiles and preferences of the IPS clients

7. Capacity in treatment partnerships, which affects the communication between IPS specialists and treatment providers. PHE explained that some of the treatment providers have faced increases in caseloads per front line worker, and may not prioritise discussing work with clients and discussing possible referrals with the IPS specialists.

B.1.2. Activities

We included the below assumptions, unintended consequences, other points:

1. Small caseloads are necessary to provide the intensive support required

2. Barriers to employment may be non-vocational (for example, low self-efficacy, fear of leaving benefits, housing needs) and also need to be addressed

3. IPS specialists have sufficient time and skills to engage with employers in the community

4. IPS specialists are able to successfully engage sufficient volumes and types of employers (levels and sectors) to meet participants’ aspirations
5. CMH suggested that the employer may need training related to the needs/characteristics of a particular client to help work with the participants.

6. The principle of IPS is not to encourage dependence of the employer on the ES.

B.1.3. Outputs
Assumptions, unintended consequences, other points:
1. Rapid job search is important to keep up the momentum and demonstrate commitment to the client.
2. Integrating employment support with dependence treatment services enables complex needs to be better addressed.
3. Support must address various concerns (for example, that starting work will leave people worse off financially, that disclosing a dependence in the workplace will result in discrimination).
4. IPS specialists have sufficient resource and capability to be able to develop and maintain relationships with employers in order to identify and better understand job opportunities.

5. These relationships allow IPS specialists to negotiate better / more suitable working conditions for participants.

B.1.4. Outcomes
Assumptions, unintended consequences, other points:
1. The client knows what they need and what might work for them.
2. The client is empowered and encouraged by the IPS specialist to co-design their path.
3. Co-location is possible and AD treatment professionals and IPS specialists are able to work together in an integrated way.
4. Potentially finding a job may have negative consequences (poor quality job, income spent on drugs or alcohol).
5. The process is not linear; people engage with the IPS service, get a job and then fall out; they engage but get frustrated, they may disengage and re-engage.

B.1.5. Impacts
Assumptions, unintended consequences, other points: none identified.
Figure 7: Original Theory of Change for the clients of the IPS service

**Input**
- Experienced and trained IPS specialists
- Financial resources to implement the IPS service
- Additional support for treatment providers

**Activity**
- Referral from treatment services
- Initial appointment with IPS specialist
- First IPS meeting and initiation of the vocational profile

**Output**
- Client takes up referral
- Client consents to take part in trial
- Client and IPS specialist develop rapport/working relation

**Outcome**
- Improved personal and social functioning
- Improved confidence
- Improved self-efficacy in job search
- Improved understanding of skills/assets and career goals
- Improved knowledge of labour market & employment options
- Increased motivation to work

**Key**
- Improved financial resilience
- Improved treatment outcomes
- Improved control over dependence while at work
- Improved health and wellbeing
- Sustained employment
- Reduced criminality
- Improved family stability/relations

**Activity**
- Client makes job applications
- Work trial
- Access to work experience opportunities
- Job carving and tailoring
- Employability support (CV, interview, prep.)
- Appraising other needs, onward referrals
- Coaching
- Regular contact with the client
- Advice on disclosure
- Advice on benefits and income
- Liaison with treatment services

**Impact**
- Client leaves job / job search and needs continuing IPS support
- Responsive in-work support for employee & employer (from regular check-ins to intensive advice/coaching)

**Key**
- Employer confident in the sustainability of the client
- Employer confident and willing to provide support
- Employer confident that they can support the client

**Source:** RAND Europe and CMH
Figure 8: Revised Theory of Change for the clients of the IPS service

NOTE: The revisions in the models are marked in red. Elements not validated in the process evaluation are marked in italics.
B.2. System-level ToC

B.2.1. Inputs
Assumptions, unintended consequences, other points:
1. The referral sources are: (i) aware of the trial; (ii) aware of and understand the referral mechanisms into the trial; and (iii) motivated to make use of the referral mechanisms.
2. The integration of IPS specialists within AD treatment teams is important for the provision of co-ordinated support to participants.

B.2.2. Activities
Assumptions, unintended consequences, other points:
1. The local leads for the trial are sufficiently resourced, skilled, networked and supported to undertake successful engagement with employment and other services.

B.2.3. Outputs
Assumptions, unintended consequences, other points:
1. Co-location or a regular presence of IPS specialists in AD treatment teams is successfully arranged

B.2.4. Outcomes
Assumptions, unintended consequences, other points:
1. There is sufficient buy-in, at the right level of seniority, among AD treatment teams to support integrated working.
2. Co-working practices become successfully embedded within teams.

B.2.5. Impacts
Assumptions, unintended consequences, other points: None identified.
Figure 9: Original Theory of Change in local treatment services implementing the IPS-AD trial

- Organisational adjustments to implement the IPS service
- Experienced and trained IPS specialists
- Financial resources to implement the IPS service
- Additional support for treatment providers

**Input**
- Feeding back outcomes for clients and any efficiency savings
- Organisational adjustments to implement the IPS service
- Experienced and trained IPS specialists
- Financial resources to implement the IPS service
- Additional support for treatment providers

**Activity**
- Engagement between AD treatment professionals and IPS specialists
- AD treatment professionals know how to make references to the IPS service
- AD treatment professionals make referrals to the IPS service
- IPS specialists share relationships and knowledge of employment services with AD treatment professionals
- IPS specialists develop relationships with employment services (JCP and commissioned programmes)
- IPS specialists are adequately managed and supervised regarding relations with AD treatment teams and employment services
- IPS specialists develop stronger relationships with AD treatment teams
- IPS champions emerge in AD treatment teams and help coordinate client support
- IPS specialists share relationships and knowledge of employment services with AD treatment professionals
- AD treatment professionals develop their own relations with employment services
- AD treatment professionals have meaningful conversations about work with clients
- AD treatment professionals include specific employment recommendations and steps in the treatment plans
- AD treatment professionals view work conversations as part of their role
- AD treatment professionals make more regular use of referrals to employment services

**Outcome**
- Feeding back outcomes for clients and any efficiency savings
- Organisational adjustments to implement the IPS service
- Experienced and trained IPS specialists
- Financial resources to implement the IPS service
- Additional support for treatment providers

**Impact**
- Better integration of IPS employment support in AD treatment services

**Key**
- Input
- Activity
- Output
- Outcome
- Impact

*SOURCE: RAND Europe and CMH*
Figure 10: Revised Theory of Change in local treatment services implementing the IPS-AD trial

NOTE: The revisions in the models are marked in red. Elements not validated in the process evaluation are marked in italics. SOURCE: RAND Europe and CMH
Endnotes

1 (Black, 2016).
2 (Black, 2016).
3 (Henkel, 2011).
4 (Black, 2016).
5 (Bond, 2008), (Bond, 2012), (Bond, 2016), (Modini, 2016).
6 For further information on the principles of IPS, please see https://www.centreformentalhealth.org.uk/what-ips (accessed 14 May 2021).
7 While in IPS, there are no criteria set for potential participants, the IPS-AD trial used several eligibility criteria. To be eligible to join the trial, participants had to be aged between 18 and 65, be enrolled in substance dependence treatment for at least 14 days, be unemployed/economically inactive for at least 6 months, able to provide their National Insurance number, able to attend the treatment services and able to communicate at a level required for psychosocial intervention. Participants were ineligible to join the trial if they: were currently receiving detoxification treatment, had clinically significant severe mental health, intellectual disability, organic brain disease or physical disability that would prevent them from accepting IPS, had had suicide planning in the past month or a suicide attempt in the last 6 months, were involved in legal proceedings that were likely to result in imprisonment, had been enrolled in another IPS trial within the last 6 months or had previously enrolled in the IPS-AD trial. For further information, please see (15).
8 In the IPS-AD trial, support to those seeking a job was provided for nine months with a further four months of in-work support after the participant gained employment. For further information, please see (15).
9 This is the UK scale, which is an adaption of the Dartmouth ‘Supported Employment Fidelity Scale’ (32). This version was adapted by Nicola Oliver, IPS Co-ordinator, CMH.
10 While used as a catch-all phrase in this report and evaluation, TSKs may be called different roles at different sites. In general, it was a member of staff at a treatment services who held a caseload of clients and coordinated their care from a substance dependence point of view. The nature of the role differed depending on the service.
11 (Pawson, 1997).
12 Creating one embedded ToC model would be difficult to represent visually. We chose to develop two separate models, even if these are interrelated, for ease of presentation.
13 The original ToC models drew on an initial documentation review, the evaluators’ understanding of the IPS model and the IPS-AD trial, and discussions with PHE (including at a workshop held on 7 June 2018).
14 SESs in the IPS-AD trial were ESs who also held responsibilities that included managing the ES team in the site and acting as PIs (liaising with PHE and other bodies within the trial).
15 (Bond, 2008), (Bond, 2012), (Bond, 2016), (Modini, 2016).
16 (Black, 2016), (Burkinshaw, 2017), (Patel, 2016).
17 (Pawson, 1997).
18 (Hofman, n.d.).
19 (RAND Europe, n.d.).
20 (Pawson, 1997).
21 The ‘Thrive into Work’ trial tests whether a modified version of the IPS model will work in primary health settings and for service users with a health condition or disability (BMC, 2020).
22 A separate Criminal Justice Team engages with clients who are currently undergoing or have recently experienced criminal proceedings.
23 Treatment services in Derbyshire are provided by a partnership between Derbyshire Healthcare NHS trust and three other organisations.
24 Wave 1: 2 stakeholders.
25 Treatment services in Sheffield are provided by SHSC NHS Trust.
26 Wave 3: one stakeholder.
27 Wave 1: 3 sites, one ES, one JCP staff, one COM.
28 Wave 3: one stakeholder.
Wave 3: one stakeholder.

Wave 2: 2 stakeholders.

Wave 3: 3 stakeholders.

Wave 2: 3 stakeholders.

Wave 3: 3 stakeholders.

Wave 3: 2 stakeholders.

Wave 3: 3 stakeholders.

Wave 2: 2 sites, one COM, one TSM; Wave 3: one COM.

Wave 2: one COM.

Wave 2: one stakeholder.

Wave 3: one stakeholder.

Wave 2: one stakeholder; Wave 3: 3 stakeholders.

Wave 2: 2 stakeholders; Wave 3: 2 stakeholders.

Wave 2: one stakeholder.

Wave 3: 2 stakeholders

Wave 3: 2 sites, one SES, one TSM.

One item (community-based services) in the IPS 25 fidelity scale covers the proportion of time that ESs spend in community-based settings.

Wave 2: one ES.

Wave 2: one ES.

Wave 2: 2 stakeholders.

Wave 3: one stakeholder.

Wave 1: one stakeholder.

Wave 2: 3 sites, 2 TSKs, 2 COMs, one TSM; Wave 3: 5 sites, 5 ESs, 3 TSMs.

Wave 2: one TSM; Wave 3: 5 ESs, 4 TSMs.

Wave 3: 2 sites, 3 ESs, one TSM.

Wave 3: 2 sites: one ES, one TSM.

Wave 3: 3 sites, 2 ESs, 2 TSMs.

Wave 3: one TSK.

Wave 1: 2 sites, 2 ESs; Wave 2: one site, one ES, one TSK, one TSM; Wave 3: 2 ESs, 2 TSMs.

Wave 2: one site, one COM, one TSK, one TSM.

Wave 3: 2 sites, one ES, one TSK.

Wave 3: 3 sites, 3 ESs.

Wave 3: one ES.

Wave 2: one COM; Wave 3: one ES.

Wave 3: one ES.

Wave 2: 3 sites, one TSM, 2 TSKs, 2 COMs; Wave 3: 5 sites, 3 ESs, 4 TSMs, one TSK, 3 COMs.

Wave 3: 4 sites, 2 ESs, 3 TSMs, 2 COMs.

Wave 3: one site, one TSM, one COM.

Wave 3: 2 sites, one ES, one TSK.

Wave 3: one TSM.

Wave 3: 3 sites, 3 TSMs.

Wave 3: 3 sites, one ES, 2 TSMs.

Wave 2: 2 TSMs.

Wave 3: one stakeholder.

Wave 3: one stakeholder.

Wave 1: 4 sites, one ES, 3 COMs.

Wave 1: 2 sites, 2 COMs.

(Marsden, 2020).

Wave 1: 5 sites, 7 ESs.

Wave 1: 4 sites, 4 ESs.

Wave 1: 2 sites, 2 ESs.

Wave 1: 3 sites, 5 ESs.

Wave 2: 3 sites, 3 ESs.

Wave 2: 3 sites, 3 ESs.

Wave 2: 6 sites, 12 ESs; Wave 3: 4 sites, 6 ESs.

Wave 2: 6 sites, 7 ESs.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: 2 sites, 2 ESs.

Wave 3: one ES.

Wave 2: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 2: 6 sites, 7 ESs; Wave 3: 5 sites, 7 ESs.

Wave 2: 6 sites, 7 ESs.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: 2 sites, 2 ESs.

Wave 3: 5 sites, 8 ESs.

(Learn, n.d.)

Wave 3: 4 sites, 4 ESs.
Process evaluation of the Individual Placement and Support for Alcohol and Drug dependence (IPS-AD) trial

Wave 3: one ES.

Wave 2: one ES; Wave 3: 3 sites, 4 ESs.

Wave 3: one ES.

Wave 2: 2 sites, 2 ESs.

Wave 3: 2 stakeholders.

Wave 3: 2 sites, 2 ESs.

Wave 2: one ES.

Wave 2: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 2: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 1: 2 sites, 3 ESs; Wave 2: one ES; Wave 3: one COM.

Wave 2: one ES.

Wave 3: one ES.

Wave 2: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 1: 5 sites, 2 TSMs, 3 TSKs; Wave 2: 3 sites, 3 ESs, one TSM; Wave 3: 5 sites, 3 ESs, 3 TSMs, 3 TSKs.

Wave 1: 5 sites, 2 TSMs, 3 TSKs; Wave 2: 3 sites, 3 ESs, 3 TSMs, 3 TSKs.

Wave 2: 3 sites, 2 ESs, one TSM, one TSK; Wave 3: one ES.

Wave 3: 2 stakeholders.

Wave 3: 3 sites, one TSM, 2 TSKs.

Wave 1: one TSK; Wave 3: one TSK; Wave 3: 2 sites, one TSM, one TSK.

Wave 3: one TSK.

Wave 3: 3 sites, 3 ESs.

Wave 3: one ES.

Wave 3: 2 sites, 3 ESs.

Wave 2: one ES.

Wave 2: one site, 2 ESs; Wave 3: one ES.

Wave 1: 2 sites, 3 ESs; Wave 2: one ES; Wave 3: one COM.

Wave 2: one ES.

Wave 3: one ES.

Wave 2: one ES.

Wave 3: one ES.

Wave 2: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 1: one TSK; Wave 3: 2 sites, one TSM, one TSK.

Wave 3: one TSK.

Wave 3: 3 sites, 3 ESs.

Wave 3: one ES.

Wave 3: 2 sites, 3 ESs.

Wave 2: one ES.

Wave 2: one site, 2 ESs; Wave 3: one ES.

Wave 3: 3 sites, one TSM, 2 TSKs.

Wave 1: one TSK; Wave 3: one TSK.

Wave 3: one ES.

Wave 2: one site, 2 ESs; Wave 3: one ES.

Wave 3: 2 stakeholders.

Wave 3: 3 sites, one TSM, 2 TSKs.

Wave 1: one TSK; Wave 3: one TSK.

For further information and a full list of inclusion and exclusion criteria, please see section 1.2 and (15).

Wave 1: 5 sites, 2 TSMs, 3 TSKs; Wave 2: 3 sites, 3 ESs, one TSM; Wave 3: 5 sites, 3 ESs, 3 TSMs, 3 TSKs.

Wave 1: 5 sites, 2 TSMs, 3 TSKs; Wave 2: 3 sites, 3 TSMs; Wave 3: 3 sites, 3 TSKs.

Wave 2: 3 sites, 2 ESs, one TSM, one TSK; Wave 3: one ES.

Wave 3: 2 ESs, one TSM, one TSK; Wave 2: 3 sites, 3 ESs, one TSM, one TSK.

Wave 3: 2 sites, one TSM, one TSK.

Wave 3: 2 sites, one TSM.

Wave 3: 2 sites, one TSM.

Wave 3: 2 sites, 3 ESs.

Wave 3: 2 sites, one TSM.

Wave 3: one ES.

Wave 3: one TSM.

Wave 1: 5 sites, 2 TSMs, 3 TSKs; Wave 2: 3 sites, 3 ESs, one TSM; Wave 3: 5 sites, 3 ESs, 3 TSMs, 3 TSKs.

Wave 1: 5 sites, 2 TSMs, 3 TSKs; Wave 2: 3 sites, 3 TSMs; Wave 3: 3 sites, 3 TSKs.

Wave 2: 3 sites, 2 ESs, one TSM, one TSK; Wave 3: one ES.

Wave 3: 2 stakeholders.

Wave 3: 3 sites, one TSM, 2 TSKs.

Wave 1: one TSK; Wave 3: one TSK.

Wave 3: one ES.

Wave 3: one TSK.

Wave 3: 2 sites, one ES, one TSK.

Wave 1: 2 sites, one COM, one TSK; Wave 2: 2 sites, one COM, one TSK; Wave 3: 2 sites, 2 ESs.

Wave 3: one TSM.

Wave 3: one TSM.

Wave 3: one TSK.

Wave 3: 2 TSKs.

Wave 3: one TSK.

Wave 1: one TSK; Wave 3: 4 sites, 4 ESs, one COM, 3 TSMs, 2 TSKs.

Wave 3: 2 sites, one ES, one TSK.

Wave 3: one ES.

Wave 3: 2 sites, one ES, one TSK.

Wave 3: one TSM.

Wave 3: one ES.

Wave 3: one TSM.

Wave 3: one TSM.

Wave 3: one TSM.

Wave 3: one TSK.

Wave 3: one TSK.

Wave 3: 3 sites, 2 ESs, one TSM.

Wave 3: one TSK.

Wave 3: 2 sites, 2 ESs.

Wave 2: 5 sites, 7 ESs, 3 TSMs; Wave 3: 3 sites, 2 ESs, one COM.

Wave 1: 2 sites, 2 ESs; Wave 2: 5 sites, 7 ESs, 3 TSMs; Wave 3: 3 sites, 2 ESs, one COM.

Wave 1: 2 sites, 2 ESs; Wave 2: 5 sites, 5 ESs, 3 TSMs; Wave 3: 3 sites, 2 ESs, one COM.

Wave 3: one COM.

Wave 3: one SES.

Wave 3: 2 sites, 3 ESs, one TSM.

Wave 3: 2 sites, 3 ESs, one TSM.

Wave 3: 3 stakeholders.

Wave 3: 3 sites, 2 ESs, 2 TSMs.

Wave 3: one ES, one TSM.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: 3 sites, 2 ESs, one COM, one TSM.
Wave 3: one ES.

Wave 3: one site, one ES, one COM.

Wave 2: 2 sites, 2 ESs, one TSM; Wave 3: 5 sites, 5 ESs, one COM.

Wave 1: 3 sites, 3 ESs, one TSK; Wave 3: 2 sites, one ES, one COM, 2 TSMs, one TSK.

Wave 3: one site, one ES, one TSM, one COM

Wave 3: 3 sites, 3 ESs, one TSM.

Wave 3: one ES.

Wave 1: 4 sites, 4 ESs, one TSK; Wave 2: 5 sites, 3 ESs, 2 TSMs, one TSK; Wave 3: 5 sites, 4 ESs, 3 TSMs.

Wave 2: 2 sites, one ES, one TSM; Wave 3: 2 ESs, one TSM.

Wave 3: one ES

Wave 3: one TSM.

Wave 3: one ES.

Wave 2: one site, one ES, one TSK.

Wave 3: one site, one ES, one TSK.

Wave 1: 2 sites, one TSK, one TSM, one ES; Wave 2: 5 sites, 8 ESs, 2 TSMs, 2 TSKs; Wave 3: 5 sites, 4 ESs, 3 TSMs, one TSK, one COM.

Wave 3: one ES.

Wave 3: 2 sites, 2 ESs.

Wave 3: one ES.

Wave 3: one TSM.

Wave 3: one TSM.

Wave 1: 3 sites, 3 TSMs; Wave 2: 3 sites, 2 ESs, one COM; Wave 3: 4 sites, 4 ESs, 2 TSMs, one COM.

Wave 3: 3 sites, 3 ESs, 2 TSMs, one COM.

Wave 3: one TSM, one COM.

Wave 3: one TSM.

Wave 3: one TSM.

Wave 3: 2 ESs, one TSM.

Wave 3: one ES.

Wave 3: one TSM.

Wave 3: one ES.

Wave 2: 2 sites, 2 ESs, one TSM.

Wave 3: 2 sites, one ES, one TSM.

Wave 3: one ES.

Wave 2: one site, 2 ESs; Wave 2: 3 sites, 4 ESs; Wave 3: one ES.

Wave 3: one ES.

Wave 3: 3 stakeholders.

Wave 2: 5 sites, 4 ESs, 2 TSMs; Wave 3: one ES.

Wave 1: 5 sites, 5 ESs, one TSM; Wave 3: 2 sites, one ES, one TSM.

Wave 1: 3 sites, 4 ESs, one COM.

Wave 3: one site, one ES, one TSM; Wave 3: 2 sites, one ES, one TSM.

Wave 3: 3 sites, 4 ESs, one COM.

Wave 3: 3 sites, 3 ESs, one TSM.

Wave 2: 2 sites, one ES, one TSM.

Wave 3: 2 sites, 3 ESs, one TSM.

Wave 3: 3 stakeholders.

Wave 3: 2 sites, 3 TSMs.

Wave 3: one ES.

Wave 3: one TSK.

Wave 1: 3 sites, one ES, one TSM; Wave 3: 3 sites, 3 ESs, 3 TSMs.

Wave 3: one TSM.

Wave 1: 2 sites, one TSK.

Wave 2: 2 sites, 3 ESs; Wave 3: 3 sites, 3 ESs, one TSK.

Wave 3: one TSK.

Wave 2: 2 sites, one ES, one TSM.

Wave 2: 2 sites, 3 ESs; Wave 3: 3 sites, 3 ESs, one TSK.

Wave 3: one TSM.

Wave 3: one site, one ES, one TSM.

Wave 3: two sites, 2 TSMs.

Wave 3: one site, one TSM, one TSK.

Wave 3: one site, one TSK.

Wave 3: one TSM, one TSK.

Wave 3: 6 sites, 5 ESs, 2 TSMs, 3 TSKs, one COM.

Wave 3: 3 sites, 3 ESs, one TSK.

Wave 3: 2 sites, one ES, one TSM, one COM.

Wave 3: 2 sites, 2 ESs.

Wave 3: one site, one TSM, one TSK.

Wave 3: one ES.

Wave 3: one TSM, one TSK.

Wave 3: 2 sites, 2 TSMs.

Wave 3: one site, one TSM, one COM.

Wave 3: one site, one TSM.

Wave 3: one COM.

Wave 3: 2 sites, 2 TSMs.

Wave 3: one site, one TSM, one COM.

Wave 3: one ES.

Wave 3: one TSM.

Wave 3: one COM.

(Brorson, 2013)

(Timko, 2016).

Wave 1: 2 sites, 3 ESs.
Wave 2: 2 sites, 2 ESs; Wave 3: 3 sites, 4 ESs, one TSK, one COM.

Wave 2: 2 sites, 2 ESs.

Wave 3: one stakeholder.

Wave 3: one stakeholder.

See ‘Assertive engagement and outreach by integrated treatment team’ in the IPS Fidelity Manual (22).

Wave 2: 2 sites, 2 ESs; Wave 3: one site, one ES, one COM.

Wave 1: 2 sites, 2 ESs; Wave 3: one site, one ES, one TSK.

Wave 1: 3 sites, 3 ESs.

Wave 2: 3 sites, 2 ESs; Wave 3: 2 sites, 2 ESs.

Wave 3: one ES.

Wave 3: 2 sites, 3 ESs.

Wave 2: 4 sites, 6 ESs; Wave 3: one ES.

Wave 3: one ES.

Wave 2: 2 sites, 2 ESs; Wave 3: 2 sites, 2 ESs.

Wave 1: 2 sites, 2 ESs.

Wave 3: one ES.

Wave 3: 2 sites, 3 ESs.

Wave 2: 4 sites, 6 ESs; Wave 3: one ES.

Wave 3: one ES.

Wave 2: one ES; Wave 3: one ES.

Wave 3: one COM.

The clinical psychologist works for the Public Health department at Derbyshire County Council, supporting the application of behaviour change approaches to improve outcomes on a range of public health-related projects.

Wave 3: 3 stakeholders.

Wave 3: one site, 3 ESs.

Wave 3: one site, 2 ESs.

Wave 3: one ES.

Wave 1: 4 sites, 4 ESs, 2 JCP staff, one TSK.

Wave 1: 2 sites, 2 ESs.

Wave 1: 2 sites, 2 ESs.

Wave 2: one ES.

Wave 1: 2 sites, 3 ESs.

Wave 1: 7 sites, 12 ESs.

For more information, see the IPS Fidelity Manual (Becker, 2019).

Wave 1: one ES.

Wave 1: 3 sites, 3 ESs.

Wave 1: one site, 3 ESs.

Wave 1: 3 sites, 3 ESs.

Wave 1: 3 sites, 4 ESs; Wave 2: 3 sites, one ES, one IPS opioids, one IPS alcohol.

Wave 2: 5 sites, one ES, 2 IPS opioids, 3 IPS alcohol.

Wave 2: one IPS alcohol.

Wave 2: 4 sites, 3 IPS alcohol, 2 IPS opioids, one IPS other drugs; Wave 3: 5 sites: 7 IPS opioids, 4 IPS alcohol, one IPS other drugs.

Wave 3: 3 sites, one IPS opioid, one IPS alcohol, one IPS other drugs.

Wave 2: 2 sites, one TSK, one IPS alcohol; Wave 3: 3 sites, one ES, one TSM, one IPS opioids, one IPS alcohol.

Wave 3: one TSM.

Wave 2: 4 sites, 3 IPS alcohol, one IPS opioids, one IPS other drugs; Wave 3: 4 sites, 3 IPS alcohol, one IPS other drugs, one IPS opioids.

Wave 3: one site, one IPS opioid.

Wave 3: one IPS opioids, one IPS alcohol, one IPS other drugs.

Wave 3: one IPS alcohol.

Wave 3: one IPS alcohol.

Wave 3: one ES.

Wave 3: one site, one ES, one IPS alcohol.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

In this evaluation, we use the term ‘disclosure’ when exploring how ESs supported clients in their decisions about whether or not to inform potential employers about their substance use history.

Wave 1: 5 sites, 5 ESs, one COM; Wave 2: 2 IPS opioids, 2 IPS alcohol; Wave 3: 4 sites, 4 ESs, one IPS alcohol, one IPS opioids.

Wave 2: 3 sites, one ES, one IPS opioids, one IPS alcohol, one TAU opioids; Wave 3: 4 sites, 4 IPS opioids, one IPS alcohol, one IPS other drugs; one TAU opioids.

Wave 2: one IPS alcohol; Wave 3: 2 sites, 2 IPS alcohol, one TAU alcohol.

Wave 2: one ES; Wave 3: one IPS alcohol.

Wave 3: 2 sites, 2 ESs.
<table>
<thead>
<tr>
<th>Wave 1</th>
<th>Waves 2 &amp; 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 sites, 5 ESs.</td>
<td>2 sites, 2 ESs.</td>
</tr>
<tr>
<td>Wave 1: 5 sites, 5 ESs.</td>
<td>Wave 3: 3 sites, 5 ESs.</td>
</tr>
<tr>
<td>Wave 1: 3 sites, 3 ESs.</td>
<td>Wave 2: 3 sites, 3 ESs; Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 3: 3 sites, 3 ESs.</td>
<td>Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 3: one ES.</td>
<td>Wave 2: one ES.</td>
</tr>
<tr>
<td>Wave 2: 2 sites, 2 ESs; Wave 3: one IPS opioids.</td>
<td>Wave 2: 2 sites, 2 ESs; Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 2: 2 sites, 2 ESs; Wave 3: one IPS opioids.</td>
<td>Wave 1: 2 sites, 2 ESs; Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 1: 2 sites, 2 ESs; Wave 3: one IPS opioids.</td>
<td>Wave 2: 2 sites, 2 ESs; Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 3: 3 sites, 2 IPS opioids, 2 IPS alcohol, one IPS other drugs, one TAU opioids.</td>
<td>Wave 2: 4 sites, 8 ESs</td>
</tr>
<tr>
<td>Wave 2: 3 sites, 2 IPS opioids, 4 IPS alcohol, one IPS other drugs.</td>
<td>Wave 2: one ES; Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 3: 4 sites, one IPS opioids, one IPS alcohol, 3 TAU opioids, one TAU alcohol.</td>
<td>Wave 2: one ES; Wave 3: 2 sites, 2 EMPLs.</td>
</tr>
<tr>
<td>Wave 3: 3 sites, 5 ESs.</td>
<td>Wave 2: one ES.</td>
</tr>
<tr>
<td>Wave 3: one ES.</td>
<td>Wave 3: 3 sites, one ES, 2 EMPLs.</td>
</tr>
<tr>
<td>Wave 3: one ES.</td>
<td>Wave 2: 4 sites, 5 ESs.</td>
</tr>
<tr>
<td>Wave 3: 2 sites, 2 ESs.</td>
<td>Wave 2: one ES.</td>
</tr>
<tr>
<td>Wave 3: one IPS alcohol.</td>
<td>Wave 2: one ES.</td>
</tr>
<tr>
<td>Wave 3: one ES.</td>
<td>Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 3: one ES.</td>
<td>Wave 2: one ES.</td>
</tr>
<tr>
<td>Wave: 3: 3 sites, 5 ESs.</td>
<td>Wave 3: 3 sites, 3 ESs.</td>
</tr>
<tr>
<td>Wave 2: 5 sites, 9 ESs, one COM; Wave 3: 2 sites, 3 ESs.</td>
<td>Wave 2: 3 sites, 4 ESs; Wave 3: 3 sites, 3 ESs.</td>
</tr>
<tr>
<td>Wave 1: one ES; Wave 2: 4 sites, 7 ESs.</td>
<td>Wave 2: 3 sites, 3 ESs; Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 3: one ES.</td>
<td>Wave 3: one ES.</td>
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<tr>
<td>Wave 3: one ES.</td>
<td>Wave 2: one ES.</td>
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<tr>
<td>Wave 3: one ES.</td>
<td>Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 2: 3 sites, 3 ESs.</td>
<td>Wave 3: 3 sites, 4 ESs.</td>
</tr>
<tr>
<td>Wave 2: 2 sites, 2 ESs, one COM; Wave 3: one ES.</td>
<td>Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 2: 2 sites, 2 ESs.</td>
<td>Wave 2: 3 sites, 5 ESs; Wave 3: 3 sites, 3 ESs.</td>
</tr>
<tr>
<td>Wave 3: one ES.</td>
<td>Wave 3: one ES.</td>
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<tr>
<td>Wave 3: one ES.</td>
<td>Wave 3: 3 sites, 3 ESs.</td>
</tr>
<tr>
<td>Wave 3: one ES.</td>
<td>Wave 3: 3 sites, 3 ESs.</td>
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<tr>
<td>Wave 2: one ES.</td>
<td>Wave 3: 2 sites, 2 ESs.</td>
</tr>
<tr>
<td>Wave 3: one ES.</td>
<td>Wave 2: 4 sites, 5 ESs.</td>
</tr>
<tr>
<td>Wave 2: one ES.</td>
<td>Wave 3: 2 sites, 2 ESs.</td>
</tr>
<tr>
<td>Wave 2: 4 sites, 5 ESs.</td>
<td>Wave 2: 4 sites, 6 ESs.</td>
</tr>
<tr>
<td>Wave 2: one ES; Wave 3: 3 sites, 4 ESs.</td>
<td>Wave 2: 3 sites, 4 ESs; Wave 3: 3 sites, 4 ESs.</td>
</tr>
<tr>
<td>Wave 3: 2 sites, 2 EMPLs.</td>
<td>Wave 3: 2 sites, 4 ESs.</td>
</tr>
<tr>
<td>Wave 2: 2 sites, 2 EMPLs.</td>
<td>Wave 3: 2 sites, 4 ESs.</td>
</tr>
<tr>
<td>Wave 3: one ES.</td>
<td>Wave 3: 2 sites, 2 ESs.</td>
</tr>
<tr>
<td>Wave 2: 2 sites, 2 ESs.</td>
<td>Wave 2: one ES; Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 2: 5 sites, 9 ESs.</td>
<td>Wave 2: 4 sites, 6 ESs; Wave 3: 4 sites, 6 ESs.</td>
</tr>
<tr>
<td>Wave 1: 2 sites, 2 ESs.</td>
<td>Wave 2: one ES; Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 2: 2 sites, 2 ESs.</td>
<td>Waves 2 &amp; 3: 2 sites, 2 ESs.</td>
</tr>
<tr>
<td>Wave 3: 2 sites, 2 ESs.</td>
<td>Wave 2: 2 sites, 2 ESs; Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 2: 2 sites, 2 ESs.</td>
<td>Wave 2: one ES; Wave 3: one ES.</td>
</tr>
<tr>
<td>Wave 2: 2 sites, 2 ESs.</td>
<td>Wave 2: one ES.</td>
</tr>
<tr>
<td>Wave 2: 2 sites, 2 ESs.</td>
<td>Wave 2: 2 sites, 2 ESs.</td>
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<tr>
<td>Wave 3: 2 sites, 2 ESs.</td>
<td>Wave 2: 2 sites, 2 ESs.</td>
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<tr>
<td>Wave 2: 2 sites, 2 ESs.</td>
<td>Wave 2: 2 sites, 2 ESs.</td>
</tr>
<tr>
<td>Wave 3: 2 sites, 2 ESs.</td>
<td>Wave 2: 5 sites, 8 ESs; Wave 3: 2 sites, 2 ESs.</td>
</tr>
<tr>
<td>Wave 3: 2 sites, 2 ESs.</td>
<td>Wave 2: 4 sites, 5 ESs; Wave 3: 2 sites, 3 ESs.</td>
</tr>
<tr>
<td>Wave 2: 2 sites, 2 ESs; Wave 3: one ES.</td>
<td>Wave 2: 2 sites, 2 ESs.</td>
</tr>
<tr>
<td>Wave 2: one ES.</td>
<td>Wave 2: one ES.</td>
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<tr>
<td>Wave 2: one ES.</td>
<td>Wave 2: one ES.</td>
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<tr>
<td>Wave 2: one ES.</td>
<td>Wave 2: one ES.</td>
</tr>
</tbody>
</table>
Wave 2: 2 sites, 2 ESs.

‘Three cups of tea’ is an IPS approach involving: first, approaching the employer to see if they will make an appointment to discuss their vacancies; second, meeting them to find out more about their business and employee positions; and third, suggesting how a particular client would meet their needs.

Waves 2 & 3: one ES.

Wave 2: 6 sites, 4 IPS alcohol, 4 IPS opioids, 2 IPS other drugs, one TAU alcohol, 3 TAU opioids.

Wave 2: 4 sites, 4 IPS alcohol, 2 IPS opioids, one TAU opioid, one TAU alcohol.

Wave 2: 3 sites, one IPS opioid, 2 IPS other drugs.

Wave 3: 5 sites, 4 IPS alcohol, 2 IPS other drugs, 2 IPS opioids, one TAU opioid.

Wave 3: one TAU alcohol.

Wave 3: 3 sites, one IPS alcohol, one IPS opioids, 2 TAU alcohol, one TAU other drugs.

Wave 3: 6 sites, one IPS alcohol, 4 IPS opioids, one IPS other drugs, one TAU opioid, 3 TAU alcohol, 2 TAU other drugs.

Wave 3: 3 sites, one IPS opioid, one IPS alcohol, one IPS other drugs, one TAU opioid.

Wave 3: 3 sites, one IPS alcohol, one IPS opioids, 2 TAU alcohol, one TAU other drugs.

Wave 3: 2 sites, one IPS opioid, one TAU alcohol.

Wave 3: 3 sites, one IPS opioid, one IPS alcohol, 2 TAU opioids, one TAU alcohol.

Wave 2: one IPS opioid.

Wave 2: 4 sites, 4 IPS alcohol, 2 IPS opioids, one TAU alcohol, 2 TAU opioids.

Wave 2: 3 sites, one IPS opioids, 2 IPS other drugs.

Wave 2: 2 sites, one IPS opioids, one IPS alcohol, one TAU opioids.

Wave 2: 4 sites, 3 IPS opioids, one IPS alcohol, 3 TAU opioids, one TAU alcohol.

Wave 2: 4 sites, one ES, one TSM, one IPS alcohol, 2 IPS other drugs, one TAU opioids, 2 TAU alcohol, one TAU other drugs.

Wave 2: 6 sites, 4 ESs, one TSM, one IPS alcohol, one TAU opioid, one TAU other drugs.

Wave 3: 6 sites, 4 IPS opioids, 7 IPS alcohol, 3 IPS other drugs.

Wave 2: one IPS alcohol; Wave 3: 4 sites, one ES, one TSM, 2 IPS opioids, one IPS alcohol.

Wave 2: 2 sites, one IPS opioid, one IPS alcohol, one IPS other drugs; Wave 3: 2 sites, 2 IPS opioids, one IPS alcohol.

Wave 2: one IPS opioids.

Wave 2: one IPS other drugs.

Wave 3: one IPS opioids.

Wave 2: one IPS alcohol.

Wave 2: 2 sites, one IPS opioid, one IPS other drugs; 2 TAU alcohol.

Wave 3: 5 sites: 2 IPS alcohol, one TAU opioids, 2 TAU alcohol, one TAU other drugs.
Wave 2: one site, 2 TAU alcohol.

Wave 2: 2 sites, one IPS alcohol, one TAU other drugs; Wave 3: 4 sites, one IPS opioid, one IPS alcohol, one TAU alcohol, one TAU other.

Wave 2: 3 sites, 2 TSK, one IPS alcohol, one TAU opioid; Wave 3: 3 sites, 6 IPS opioids.

Wave 3: one EMPL.

Wave 3: 7 sites, 7 IPS opioids, 7 IPS alcohol, 3 IPS other drugs.

Wave 3: 2 sites, 2 IPS alcohol, one IPS other drugs.

Wave 3: one IPS opioid.

Wave 3: 2 sites, one IPS alcohol, one IPS opioids.

Wave 3: one IPS alcohol.

Wave 3: 2 sites, one IPS opioids, 2 IPS alcohol.

Wave 3: 2 sites, 2 IPS opioids.

Wave 3: one IPS alcohol.

Wave 3: 2 sites, 2 IPS alcohol.

Wave 3: 2 sites, 2 IPS opioids.

Wave 3: 3 sites, 2 IPS opioid, one IPS alcohol, one IPS opioids, one TAU alcohol.

Wave 3: 4 sites, one IPS opioid, one IPS alcohol, one TAU alcohol, one TAU other drugs.

Wave 3: 3 sites, 2 IPS opioid, one IPS alcohol.

Wave 3: one IPS alcohol, one IPS opioids.

Wave 3: 4 sites, one IPS opioids, one IPS alcohol, one TAU alcohol.

Wave 3: 2 sites, one IPS opioids, one IPS alcohol, one TAU opioids, one TAU opioid.

Wave 3: 2 sites, 2 IPS alcohol.

Wave 3: 4 sites, one IPS opioid, one IPS alcohol, one TAU alcohol.

Wave 3: 2 sites, 2 IPS alcohol.

Wave 3: 7 sites, 7 IPS opioids, 7 IPS alcohol, 5 IPS other drugs, 7 IPS alcohol, 3 TAU opioid, 3 TAU alcohol, 3 TAU other drugs.

Wave 3: one JCP staff.

Wave 3: one IPS opioid, one IPS alcohol.

Wave 3: one TAU opioid, one TAU alcohol.

Wave 3: one TAU opioids, one TAU alcohol.

Wave 3: 3 sites: 2 IPS opioids, 3 IPS alcohol, 2 TAU opioids, one TAU alcohol, one TAU other drugs.

Wave 3: one IPS alcohol.

Wave 3: one IPS opioids.

Wave 3: 4 sites, one IPS opioids, one IPS alcohol, one TAU opioids, 2 TAU alcohol.

Wave 3: 4 sites, 2 IPS opioids, one IPS alcohol, 2 TAU opioids.

Wave 2: one IPS alcohol.

Wave 3: one IPS alcohol.

Wave 3: one IPS alcohol.
Wave 3: 2 sites, one TSM, one IPS other drugs, 2 TAU alcohol.

Wave 3: one TSM.

Wave 3: one TAU alcohol.

Wave 3: one TSM.

Wave 3: one IPS other drugs.

Wave 3: one IPS alcohol.

Wave 3: one ES.

Wave 3: one IPS alcohol.

Wave 3: one IPS alcohol.

Wave 3: one TAU alcohol.

Wave 3: one IPS alcohol.

Wave 2: one IPS alcohol.

Wave 1: 2 sites, 3 TSKs.

Wave 1: one TSK.

Wave 1: one TSM.

Wave: 1 one ES.

Wave 2: 3 sites, 2 IPS alcohol, one TAU other drugs; Wave 3: 4 sites, one ES, 3 IPS opioids, one IPS alcohol, 2 IPS other drugs.

Wave 2: one IPS alcohol.

Wave 3: 2 sites, 2 IPS opioids.

Wave 2: 2 sites, one ES, one IPS alcohol; Wave 3: one IPS opioids.

Wave 2: 2 sites, 2 TSKs.

Wave 3: 2 sites, 2 IPS opioids, 2 IPS alcohol.

Wave 3: one IPS alcohol.

Wave 3: one IPS opioids

Wave 3: 2 sites, 2 IPS opioids.

Wave 3: 4 sites, 4 ESs, 3 TSMs, one COM, 3 TSKs.

Wave 3: 3 sites, 2 TSMs, one TSK.

Wave 3: one TSM.

Wave 2: one TSK.

Wave 2: 6 sites, 6 ESs.

Wave 2: 2 sites, one TAU opioids, one TAU alcohol; Wave 3: one TAU alcohol.

Wave 3: 6 sites, 5 ESs, one TSM.

Wave 3: 3 sites, 3 ESs, one TSM.
Wave 3: one TSK.
Wave 3: 2 sites, one TSK, one COM.
Wave 3: 2 sites, 2 TSKs.
Wave 1: one TSK; Wave 2: one site, 2 ESs, one TSM; Wave 3: one TSK.
Wave 2: 5 sites, 4 ESs, one TSM, 5 TSKs; Wave 3: 2 sites, 2 TSKs, one IPS other drugs.
Wave 3: 2 sites, one TSM, one COM.
Wave 3: 3 stakeholders.
Wave 3: 2 stakeholders.
Wave 3: one stakeholder.
Wave 3: 2 stakeholders.
Wave 3: 3 stakeholders.
Wave 3: one stakeholder.
Wave 3: 2 stakeholders.
Wave 3: 3 stakeholders.
Wave 3: one stakeholder.
Wave 3: 2 stakeholders.
Wave 3: 4 stakeholders.
Wave 3: one stakeholder.
Wave 3: 2 sites, 2 ESs.
Wave 3: 2 site, 2 ESs.
Wave 2: 2 sites, 2 TSMs, 3 TSKs.
Wave 3: 2 sites, 2 ESs.
Wave 3: one TSM, 3 TSKs.
Wave 3: 2 sites, 2 ESs.
Wave 3: 3 sites, 5 ESs, one TSM.
Wave 3: one TSM, one COM.
Wave 3: 3 sites, 5 ESs, one TSM, one COM.
Wave 3: one ES.
Wave 3: one ES.
Wave 3: one site, 2 ESs.
Wave 3: one ES.
Wave 3: 4 sites, 3 ESs, 2 TSMs, one COM.
Wave 3: one COM.
Wave 3: one ES.
Wave 3: one ES.
Wave 3: 4 sites, 5 ESs, one TSM.
Wave 3: one ES.
Wave: 2 sites, 2 ESs.
Wave 3: 3 sites, 5 ESs, one TSM.
Wave 3: one ES.
Wave: 2 sites, 2 ESs.

The Access to Work programme is a publicly funded employment support programme that helps people with disabilities and health conditions access employment and helps employers make reasonable adjustments to their workplace (HMG, n.d.).

Maximus is a consultancy that provides end-to-end health and employment services across the UK (Maximus, n.d.).

Wave 3: one stakeholder.
Wave 2: 2 sites, 4 stakeholders; Wave 3: 2 sites, 3 stakeholders.
Wave 3: 2 stakeholders.
Wave 3: one stakeholder.
Wave 3: 2 stakeholders.
Wave 3: 3 stakeholders.
Wave 3: one stakeholder.
Wave 3: 2 stakeholders.
Wave 3: 3 stakeholders.
Wave 3: one stakeholder.
Wave 3: 2 stakeholders.
Wave 3: 3 stakeholders.
Wave 3: one stakeholder.
Wave 3: 2 sites, 3 ESs.
Wave 3: 2 ESs.
Wave 2: one ES.
Wave 3: 2 ESs, 2 JCP staff.
Wave 3: 2 ESs.
Wave 3: 2 ESs.
Wave 3: one ES.
Wave 3: 3 ESs, one JCP staff.
Wave 1: 5 sites, 8 ESs, 2 JCP staff.
Wave 3: 2 sites, 3 ESs, one JCP staff.
Wave 3: one ES.
Wave 3: 4 sites, 4 ESs, 2 IPS alcohol.
Wave 2: 2 sites, 2 ESs; Wave 3: 3 sites, 3 ESs, one JCP staff.
Wave 1: 4 sites, 4 JCP staff.
Wave 1: 4 sites, 4 ESs.
Wave 3: 2 sites, 2 ESs.
Wave 3: one ES.
Wave 3: 2 ESs.
Wave 3: one JCP staff.
Wave 3: 3 sites, 3 ESs.
Wave 3: 2 sites, 2 ESs.
Wave 3: 4 sites, 6 ESs, 2 JCP staff.
Wave 3: 4 sites, 5 ESs, 2 JCP staff.
Wave 3: 4 sites, 5 ESs, one JCP staff.
Wave 3: 6 sites, 6 ESs, 2 JCP staff.
Wave 3: 4 sites, 5 ESs, 2 JCP staff.
Wave 3: one ES.
Wave 3: one ES.
Wave 3: 2 ESs.
Wave 3: one ES.
Wave 1: one ES; Wave 3: 6 sites, 7 ESs, one JCP staff.
The Work and Health Programme is an employment support programme launched by the DWP in 2017 (36).

Wave 3: one ES.

Wave 3: 3 stakeholders.

Wave 3: 2 stakeholders.

Wave 3: 2 stakeholders.

Wave 1: 4 sites, 4 JCP staff.

Wave 1: 4 sites, 4 JCP staff; Wave 2: 2 sites, 3 ESs; Wave 3: 2 sites, 2 ESs.

Wave 3: one ES.

Waves 2 & 3: 3 stakeholders.

Wave 3: one JCP staff.

Wave 3: 2 sites, 2 JCP staff.

Wave 2: 3 sites, 6 ESs; Wave 3: one ES.

Wave 2: one stakeholder.

Wave 3: one JCP staff.

Wave 3: one ES.

Wave 3: one ES.

Wave 2: 7 sites, 12 ESs; Wave 3: 6 sites, 9 ESs.

Wave 2: 6 sites, 6 ESs; Wave 3: 2 sites, 3 ESs.

Wave 2: 4 sites, 6 ESs; Wave 3: 3 sites, 3 ESs.

Wave 2: 3 sites, 5 ESs; Wave 3: 3 sites, 4 ESs.

Wave 3: 2 sites, 3 ESs.

Wave 3: 3 sites, 4 ESs.

Wave 2: 2 sites, 2 ESs; Wave 3: 2 sites, 3 ESs.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 2: 2 sites, 2 ESs; Wave 3: 2 sites, 3 ESs.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 2: 7 sites, 12 ESs; Wave 3: 6 sites, 9 ESs.

Wave 2: 6 sites, 6 ESs; Wave 3: 2 sites, 3 ESs.

Wave 2: 4 sites, 6 ESs; Wave 3: 3 sites, 3 ESs.

Wave 2: 3 sites, 5 ESs; Wave 3: 3 sites, 4 ESs.

Wave 3: 2 sites, 3 ESs.

Wave 3: 3 sites, 4 ESs.

Wave 2: 2 sites, 2 ESs; Wave 3: 2 sites, 3 ESs.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 2: 7 sites, 12 ESs; Wave 3: 6 sites, 9 ESs.

Wave 2: 6 sites, 6 ESs; Wave 3: 2 sites, 3 ESs.

Wave 2: 4 sites, 6 ESs; Wave 3: 3 sites, 3 ESs.

Wave 2: 3 sites, 5 ESs; Wave 3: 3 sites, 4 ESs.

Wave 3: 2 sites, 3 ESs.

Wave 3: 3 sites, 4 ESs.

Wave 2: 2 sites, 2 ESs; Wave 3: 2 sites, 3 ESs.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 3: one ES.

Wave 2: 7 sites, 12 ESs; Wave 3: 6 sites, 9 ESs.

Wave 2: 6 sites, 6 ESs; Wave 3: 2 sites, 3 ESs.

Wave 2: 4 sites, 6 ESs; Wave 3: 3 sites, 3 ESs.

Wave 2: 3 sites, 5 ESs; Wave 3: 3 sites, 4 ESs.

Wave 3: 2 sites, 3 ESs.

Wave 3: one ES.

Wave 2: 7 sites, 12 ESs; Wave 3: 6 sites, 9 ESs.

Wave 2: 6 sites, 6 ESs; Wave 3: 2 sites, 3 ESs.

Wave 2: 4 sites, 6 ESs; Wave 3: 3 sites, 3 ESs.

Wave 2: 3 sites, 5 ESs; Wave 3: 3 sites, 4 ESs.

Wave 3: 2 sites, 3 ESs.

Wave 3: 3 sites, 4 ESs.

Wave 2: 2 sites, 2 ESs; Wave 3: 2 sites, 3 ESs.

Wave 3: one ES.

Wave 2: 7 sites, 12 ESs; Wave 3: 6 sites, 9 ESs.

Wave 2: 6 sites, 6 ESs; Wave 3: 2 sites, 3 ESs.

Wave 2: 4 sites, 6 ESs; Wave 3: 3 sites, 3 ESs.

Wave 2: 3 sites, 5 ESs; Wave 3: 3 sites, 4 ESs.

Wave 3: 2 sites, 3 ESs.

Wave 3: 3 sites, 4 ESs.

Wave 2: 2 sites, 2 ESs; Wave 3: 2 sites, 3 ESs.

Wave 3: one ES.

Wave 2: 7 sites, 12 ESs; Wave 3: 6 sites, 9 ESs.

Wave 2: 6 sites, 6 ESs; Wave 3: 2 sites, 3 ESs.

Wave 2: 4 sites, 6 ESs; Wave 3: 3 sites, 3 ESs.

Wave 2: 3 sites, 5 ESs; Wave 3: 3 sites, 4 ESs.

Wave 3: 2 sites, 3 ESs.

Wave 3: 3 sites, 4 ESs.
Wave 3: 2 sites, 2 ESs.

Wave 2: one ES; Wave 3: one TSK.

(Picken, 2021).

IPS-LITE was an RCT of time-limited IPS where participants were referred back to their mental health teams if still unemployed at 9 months or after 4 months of in-work support. (Burns, 2015).

Wave 3: 6 sites, 7 ESs, 3 COMs.

Some of these ESs, however, noted that there were changes to the IPS model that were required by the nature of the trial: such as the eligibility criteria and the presence of the control group. These aspects would not usually form part of an IPS service.

Wave 1: one site, one COM, one TSM; Wave 3: 3 sites, 3 ESs, one TSM.

Wave 2: 3 sites, 3 ESs; Wave 3: one ES.

Wave 3: one ES.

Wave 1: 3 sites, 3 ESs.

Wave 1: one ES.

Wave 1: 2 sites, 2 ESs.

Wave 3: 6 sites, 6 TSMs, 3 TSKs, 5 COMs.

Wave 3: 3 sites, 2 TSMs, one COM.

Wave 3: 3 sites.

Wave 3: one TSM.