A demonstration of integrated employment support in primary care

Formative evaluation report

April 2013

The NATIONAL CENTRE *of* MENTAL HEALTH RESEARCH, INFORMATION *and* WORKFORCE DEVELOPMENT

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Frequently used terms

Terms	Explanation
Evidence-based supported employment (EBSE), Individual placement and support	Individual placement and support is a proven approach to supported employment with adults who are in contact with secondary mental health services. Research has been conducted to understand the effectiveness of the approach and, as a result, there are now an agreed set of eight principles underlying the practice. Each principle is underpinned by its own evidence base. As a result, individual placement and support is also known as evidence-based supported employment or EBSE. EBSE is the term used throughout this document.
The Supported Employment Fidelity Scale	As with other evidence-based practices, EBSE has a practice measurement scale, which is a tool that can be used to measure the degree of implementation of the eight principles. The scale is both a service improvement tool and a research instrument. The Supported Employment Fidelity Scale is a validated measure developed by Dartmouth College in the United States, and there is now an Australasian version of this scale, which has been developed and agreed with Dartmouth. The Australasian scale was used in this evaluation.
Employment consultant (EC), employment advisor, employment specialist	The research literature on EBSE refers to the person who provides one-to-one employment support services as the 'employment specialist'. Providers of EBSE programmes use a variety of terms to describe the employment specialist, such as employment advisor or consultant. Workwise Employment use the term employment consultant, so this term has been adopted in this report, abbreviated to EC.
Patient, client	Individuals who are supported by the employment demonstration are referred to as patients by the general practitioners (GPs) and other health professionals, but clients of the employment service by Workwise. These terms are therefore used interchangeable in this evaluation report, depending on the context.
Welfare reform	The Ministry of Social Development has announced a programme of work to implement the recommendations outlined in the Welfare Working Group's report (Rebstock et al., 2011), which will come into effect from July 2013. This includes a number of changes that impact on people with health conditions and disabilities, particularly an increased focus on providing greater access to employment support services and taking an investment approach to reduce long-term benefits dependency. The term welfare reform is used throughout this report to refer to these proposed changes.
NorthCare model of care sites	The model of care was launched in April 2011 in three general practices: NorthCare Pukete Road, NorthCare Grandview and NorthCare Thomas Road. *"The model of care puts the patient and their needs are at the centre of the care, and the general practice team maintains a common focus on simplifying and enhancing the patient's journey through the health system"* (Midlands Health Network, 2011).

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"The international research is getting stronger by the day – having a job is good for your health – and being unemployed is not."

Hon. Tony Ryall, Minister of Health, speech at the opening of the Hawera Integrated Family Health Centre, September 2012

"Prior to this pilot we have suggested that people take time off work. Maybe this hasn't been the best thing to advise, but it's the only option we've had. Now that an employment consultant is part of our team we can shoulder tap them and it will be more collegial."

GP, Midlands Health Network

"It's not just people who haven't been working for donkey's years. Even if somebody hasn't been employed for the last few weeks. I'm a big believer that work is good for people. Anybody who is not employed who has the potential to be employed, I think do whatever it takes to get them into a job."

GP, Midlands Health Network

1. Introduction

This report presents findings from a formative evaluation of the Hamilton primary care employment support demonstration programme. The programme follows the principles of evidence-based supported employment (EBSE). It therefore involves the integration of employment consultants (ECs) into general practice clinics, to provide employment support to patients with mental health conditions who are receiving treatment through primary care, to either return to work or enter the workforce. The programme is being delivered through a partnership between Workwise, a non-government provider of employment support services and Midlands Health Network primary health organisation, along with Waikato Work and Income. The programme commenced 1 February 2012, and will continue for 18 months until 30 June 2013. The formative evaluation presented in this report covers the initial establishment and implementation of the demonstration project between 1 February and 31 July 2012.

The formative evaluation sits within an overall programme of evaluation of integrated employment support which will include formative, process and outcome evaluation. Undertaken alongside the implementation, the evaluation will provide New Zealand-specific evidence on the design, implementation and outcomes of employment support programmes in general practice. With established evidence on what makes effective employment support in secondary mental health services, a core aim of the evaluation is to examine the applicability of EBSE principles in general practice and other primary care settings, and identify what quality and effective application looks like.

Evaluation of the demonstration programme is particularly important because the programme is the first of its kind in New Zealand. The programme represents a sea change from the way general practice and employment support services have operated together. Primary care patients who experience a mental health condition would, in general, like to work, but there is a vacuum in terms of integrated employment support services. Furthermore, general practitioners (GPs) routinely provide work capacity medical certificates without having direct access to downstream services to refer patients to. The programme directly addresses these gaps in existing services.

The programme of evaluation overall reflects Te Pou's and the Wise Group's commitment to developing knowledge that will build the capacity of New Zealand's health system and will support evidence-informed decisions on programme design, services and policy-making.

This formative evaluation considers the feasibility of establishing employment support in line with EBSE principles within primary care, and examines enabling and constraining factors within this context. Early impacts and areas for ongoing programme development are identified. Chapter 2 of this report summarises the main evaluation findings and offers direction for the ongoing development and implementation of the demonstration programme. In Chapter 3, the evidence and rationale for the provision of integrated employment support is reviewed and the wider political and social drivers enabling the establishment of such support are identified. Chapter 4 describes the aim and objectives of the formative evaluation, key evaluation questions, the evaluation approach, and the methods used to collect and analysis the data. Limitations of the evaluation are also

identified. Chapter 5 describes the establishment process and discusses the implications of this for the ongoing implementation process of the demonstration project, and the replication of the programme to other sites and regional areas. The focus of this section is the organisational-level enablers and constrainers. Chapter 6 describes and assesses the first six months of implementation, and focuses on the feasibility and challenges of applying the integration principle of EBSE, and what this integration looks like. Chapter 7 presents the main findings resulting from the quality review , while Chapter 8 outlines the early outcomes from the programme. Finally, Chapter 9 discusses the implications of the evaluation findings.

The formative evaluation report will support increased understanding of integrated employment support programmes, and the requirements for their initial establishment and implementation. Attention is drawn to the policy and funding frameworks needed to initiate and support evidence-based employment support in general practice, and to ensure that such support is widely available.

2. Key findings and future direction

This section summarises the key formative evaluation findings, and offers direction for the ongoing development and implementation of the demonstration programme.

The evaluation found that it is possible to integrate an employment support programme in general practice clinics within a six month period. Good levels of integration were evidenced by the degree to which the EC was known to the professionals within the practice, the ease of the referral pathway, the degree of coordination of care between the services, and the use of and perceived value of the service by GPs and other health professionals.

Employment and mental health is a whole-of-government issue, and needs these cross-agency and cross-sector partnerships in order to address the inequalities that people with mental health conditions face in trying to return to work, as well as in trying to stay in employment.

The evaluation findings point to the feasibility, value and importance of integrated employment support programmes in general practice. The findings highlight the importance of cross-agency partnerships in the establishment, ongoing development and sustainability of employment support programmes for people with mental health conditions. Employment and mental health is a whole-of-government issue, and needs these cross-agency and cross-sector partnerships in order to address the inequalities that people with mental health conditions face in trying to return to work, as well as in trying to stay in employment.

2.1 Key findings

Project establishment and early implementation

Workwise and Midlands Health Network have established an employment support programme at selected general practices, in initial collaboration with Waikato Work and Income.

- The employment support programme is now an established part of three Midlands Health Network general practices. Following this establishment, the programme is set to expand into other general practices in the local area.
- The ECs have established good working relationships with the practice staff as part of the provision of holistic and coordinated patient care.
- Programme partners are receptive to the principle of integrating employment support services. Furthermore, the GPs interviewed described the project as meeting patients' needs which they could not otherwise fully respond to or support. This was particularly for patients who have been out of work for some time or who are at risk of losing their job due to a mental health condition.
- The expansion of the programme to other sites and a relaxing of the eligibility criteria was in part a result of direct pressure from GPs to increase access to the programme.
- Given its recent introduction, the programme is aligning well with the principles of evidence-based practice, as determined through an initial quality review against key aspects of the Supported

Employment Fidelity Scale. For example, the findings indicate that, in line with the principle of zero exclusion, GPs are generally not screening on their view of a patient's job readiness, but referring all eligible patients.

Achieving integration

The following factors were identified as necessary to support the integration of employment support into general practice. Not all of the factors were present at all sites, so their relative importance to supporting integration would need further exploration. These factors were:

- The presence of a primary care culture that facilitates a coordinated, cross-disciplinary approach to patient care.
- The physical presence of ECs on site, including their participation in practice meetings.
- ECs who have a track record of providing EBSE, and experience of general practice settings.
- A sufficient level of patients eligible for the programme enrolled within the practice (particularly a high proportion of patients in receipt of sickness benefits).
- The stakeholder groups (i.e. health, welfare and NGOs) working collaboratively and identifying shared objectives.
- Ongoing support from senior leadership within all key stakeholder organisations.

Initial programme impacts

The formative evaluation shows that the programme has raised stakeholder awareness regarding the role of employment in improving health and promoting recovery, and increased the frequency of employment-related conversations in general practice. The findings indicate that this awareness-raising function of the programme has been supported by:

- The ECs having an ongoing physical presence in the practice, which acts as a prompt to bring the relationship between work and health more to the forefront
- The availability and provision of employment support, in parallel with pharmacological and psychological treatments. This coordination of care was particularly evident between GPs, the primary mental health coordinator and the ECs, and also between GPs, pharmacists and ECs. As relationships with the ECs strengthen across the practices, such coordination is likely to become more widespread.

2.2 Conclusions and future direction

Integrating employment support within general practice and other primary care settings

- It is timely and appropriate to address the health impacts of long-term unemployment for people with mental health conditions by providing evidence-based employment support through GP clinics. This is in part due to the evidence of the efficacy of such support in secondary care settings and a supportive policy and practice environment, including developments in health care and welfare reform. The provision of employment support in primary care is particularly aligned to a prevention and early

intervention approach. It also aligns to the investment approach to welfare reform, where the capacity and capability of beneficiaries to achieve employment is actively developed.

- Assuming sufficient numbers of eligible patients, the demonstration programme shows it is feasible to integrate an employment support programme into general practices. GPs and other health professionals are supportive of the intervention. They see it addressing an unmet need, and providing an evidence-based alternative to the potential default position of signing off a further period of sickness absence from work through a medical certificate.
- The regular physical presence of ECs within the practice is important. However, further evaluation is needed to determine what constitutes a sufficient presence and what this means for optimally locating ECs. It would also be useful to explore whether the need for the physical presence changes over time. For example, as GPs become more familiar with this model of working would the same level of contact with the EC be required?
- The availability and provision of employment support within general practice raises awareness and reinforces the importance of employment support as a health intervention.
- The initial formative evaluation findings suggest there would be value in instituting more consistent protocols and practices across general practice in relation to integrating employment support. These protocols may include examining how GPs initiate employment conversations with patients, the information and processes used by GPs and patients to examine employment support as an option, the process of issuing and reviewing a medical certification and the provision of employment support in coordination with Work and Income.
- Sustainable funding mechanisms are required to enable the provision of employment support in primary care settings. Such mechanisms will require partnerships between service providers, Work and Income, primary health organisations and district health boards. In general, employment support programmes have the potential to increase the quality of the working relationship between primary care and Work and Income.

Programme establishment and initial implementation

- Having all three partners – non-government organisations, health, and social care services, including welfare – committed at a senior leadership level is very important to the establishment, as well as the ongoing implementation and sustainability of evidence-based employment support.
- Using experienced ECs with knowledge of primary care is likely to speed up the early implementation; this is particularly important where demand is high.
- Integrating employment services is much more than ongoing communication. Integration requires collaboration, involving ongoing relationship building, regular feedback on patient progress and a good shared understanding of the different needs, interests and role-specific perspectives of GPs and other health professionals.
- There is a need to establish smooth, seamless referral systems between the health professionals and the ECs. Systems that facilitate shared record-keeping and ongoing communication are important for sustaining implementation (e.g. IT capability that ensures that EC notes are flagged and accessible in patient management software for the referring doctor).

Alignment with the evidence-base

Following an initial quality review of the demonstration programme against aspects of the Supported Employment Fidelity Scale, directions for development of the programme include the following.

- The need to further embed employment support within the general practices, particularly through increasing the frequency of the ECs' interactions with GPs, tailoring the nature of these interactions to align with their workflows, and developing the role and input of the employment programme team leader as outlined in the fidelity scale.
- Improve the coordination of employment support and clinical treatment for enhanced patient care through cross-agency supervisory support.
- Strengthen the relationships with Work and Income case managers to increase the coordination of employment support services.

Direction for process and outcome evaluation

The formative evaluation indicates that process and outcome evaluation questions to address in phase two of the evaluation could include the following.

- Does an integrated employment support programme influence the willingness of GPs to talk with their patients about the health impacts of being out of work and the health benefits of work?
- Does an integrated employment support programme affect the medical certification process and how? What does an effective employment support programme, with sufficient fidelity to all EBSE principles, in primary care look like? Are adaptations of the EBSE fidelity scale to a primary care context appropriate and necessary?
- Is the intensity of employment support that is needed different in primary care to secondary mental health services and, if so, what impact does this have on caseload size, length of ongoing support required and other key principles of EBSE?
- What level of employment results can reasonably be expected of a primary care-based employment intervention?
- What causes significant variations in implementation such that employment success is enhanced or impeded?
- What is the role, function and fit of employment support in primary care, in the context of current welfare reforms that increasingly focus on investment in supporting employment outcomes for people with health conditions and/or disabilities?

3. The underpinning evidence and the wider political and social drivers

This section provides an overview of the evidence which provides the underpinning rationale for the provision of employment support in general practice. It then discusses some of the wider political and social drivers enabling the establishment of employment support in primary care settings in New Zealand.

The Hamilton demonstration programme is being implemented at a time when employment and mental health is emerging as a whole-of-government issue. Health and welfare reforms are simultaneously highlighting the importance of employment support for people of working age who are unemployed, and the interventions needed to improve and foster the health of the working-age population. This context indicates the potential for establishing integrated programmes that pool resources, address common objectives and seek shared outcomes.

3.1 Evidence-based supported employment

Evidence-based supported employment is 'a well-defined, rigorously tested service model' to support people with mental health conditions who are accessing secondary mental health services to secure and sustain employment (Drake et al., 2012). It is also known as the Individual Placement and Support approach to supported employment (IPS). There are eight principles to EBSE, each underpinned by evidence of its effectiveness in leading to employment outcomes (Bond, 2004). Individual Placement and Support is therefore now recognised as an evidence-based practice (William, 2006), and the term EBSE used synonymously with IPS.

Principles

The eight principles of EBSE practice are listed below and are described in more detail in Figure 1.

1. Eligibility is based on individual choice (zero exclusion).
2. Employment integrated with clinical treatment.
3. Competitive employment is the goal.
4. Rapid job search (within 4 weeks).
5. Individualised job finding, and all assistance tailored to individual.
6. Continuous support.
7. Financial planning.
8. Systematic job development.

> Evidence-based support employment (EBSE) is 'a well-defined, rigorously tested service model' to support people with mental health conditions who are accessing secondary mental health services to secure and sustain employment (Drake, Bond, & Becker, 2012).

Figure 1: The eight EBSE principles

EBSE differs substantially from traditional vocational rehabilitation. Vocational rehabilitation uses a 'train then place' approach. Under the traditional approach, a lengthy period of training and assessment occurs prior to job search and acquisition. EBSE is based on a 'place then train' philosophy emphasising a rapid individualised search for competitive employment on referral to the programme. Continuous tailored support to both the employee and employer once employment has been secured is a key component.

The EBSE approach involves intensive individual support with the aim of finding paid employment in the open job market. ECs and health professionals work as a team to support employment as a key aspect of people's treatment and recovery. There is an emphasis on job development, working in collaboration with local employers. ECs work closely with job seekers and employers to match clients to jobs and to actively support them once employed.

Appendix A provides a more detailed description of how the eight principles of EBSE could be operationalised in primary care and what this might look like. Seven of the principles seem likely to be operationalised in very much the same way they are in secondary care. The challenge is how to operationalise the principle of integration of employment support with clinical treatment in general practice. What is the equivalent of the secondary care multidisciplinary team? This is therefore the focus of Chapter 6 of this report: to understand how the team formed and the enablers and challenges to this component of the programme.

Employment consultants and health professionals work as a team to support employment as a key aspect of people's treatment and recovery.

Efficacy

The efficacy of EBSE has been demonstrated in over 16 randomised controlled trials conducted across more than eight countries (Hoffmann, Jäckel, Glauser, & Kupper, 2012). EBSE is three times more effective at supporting people into competitive employment than traditional vocational rehabilitation services (Bond et al., 2012). EBSE outperforms the controls, with 62 per cent of participants gaining a competitive employment outcome, compared to only 23 per cent in the control group (Bond et al., 2012). Comparing employment outcomes from these two groups shows that on average people receiving EBSE get into work quicker, work longer hours and earn more (Bond, Drake, & Becker, 2008). Ten-year follow up studies show at least a third of the EBSE group become regular consistent workers and therefore reduce their use and reliance on mental health services and welfare payments (Becker, Whitley, Bailey, & Drake, 2007; Salyers, Evans, Bond, & Meyer, 2004). Furthermore, contrary to widely held beliefs, there is no evidence to support the view that going back to appropriate work has a negative impact on mental health symptoms (Burns et al., 2007). In fact, returning to work can actually reverse the negative health effects of being out of work for a long time (Waddell & Burton, 2006). Research has also shown that EBSE is transferable across countries and different cultural contexts (Burns et al., 2007). Inherent in its design is the ability to work with people who have an ongoing and fluctuating mental illness. The approach ensures early access to both employment support whilst a person is receiving treatment and to clinical support whilst a person is working.

EBSE outperforms the controls, with 62 per cent of participants gaining a competitive employment outcome, compared to only 23 per cent in the control group (Bond, Drake, & Becker, 2012).

A 25-item validated fidelity scale is used to assess the extent an EBSE programme is implementing the outlined principles. Employment programmes that align more closely with the principles achieve better outcomes (Drake et al., 2012). Fidelity reviews are therefore an important quality improvement process. The use of a fidelity scale to measure psychosocial interventions contrasts with other interventions, such as cognitive behavioural therapy, where no such fidelity scale exists (Lockett & Bensemann, in press). There is now an Australasian version of the fidelity scale which is used to assess the fidelity of programmes in New Zealand (Waghorn & Lintott, 2011).

The integration principle

One of the distinguishing features of EBSE, compared to other approaches to employment support, is the principle of integrating employment support with clinical treatment. Employment advisors or consultants are assigned to clinical treatment settings. Research has shown that this increases clinicians' awareness of employment as part of recovery, facilitates early referral to employment support services, encourages employment and clinical support agencies to plan jointly, and is more effective than non-integrated brokerage employment support services (Drake, Becker, Bond, & Mueser, 2003; Drake et al., 2012).

Integration is understood and operationalised around two broad elements – through the physical attachment of ECs to clinical teams, and through their participation as an equal member of the clinical team.

In secondary mental health services, one full time EC is assigned to no more than two multidisciplinary clinical teams, so that the number of people with whom the EC needs to coordinate support services is manageable. Being a full member of the clinical team means the EC participates in shared treatment team meetings, aligns the employment support plans with the treatment plans (through shared records), and is a champion for the interdependency between employment and mental health. They encourage clinicians to think about employment for all the patients they see, and ensure that patients are able to access timely clinical support if needed once they start working. These elements of integration are referred to **as assignment** and **quality of contact** in the Supported Employment Fidelity Scale. Indicators of these components of integration in secondary mental health services, and as described in the scale, are outlined in Table 3.

At the same time, to ensure clients are not getting conflicting messages and supports, the EC also needs to coordinate their services with those offered to the individual client by the public vocational rehabilitation services. In New Zealand, this is the generic employment support service offered by Work and Income. High-fidelity programmes have regularly scheduled monthly meetings with Work and Income case managers, and weekly phone or email contact to discuss shared clients and referrals and coordinate services. This exchange of information helps to ensure clients are able to access any additional assistance which is available to all welfare beneficiaries through Work and Income. The EC also uses this relationship with Work and Income to access expert individualised assistance, to better understand how earnings will affect welfare benefits before clients start employment, when their hours increase or they change jobs. These aspects of their role are also outlined in the Supported Employment Fidelity Scale in Table 3.

Whether and how the described Work and Income relationship and role is operating in the demonstration was not examined in-depth as part of the formative evaluation.

Table 1: Supported Employment Fidelity Scale: Integration items

Brief description	Detailed description of fidelity item
Through assignment	EC are part of up to two mental health treatment teams from which at least 90 per cent of the ECs' caseload is comprised.
Through quality of frequent contact	EC participate in meetings that discuss individual clients and with shared decision-making. Documentation of mental health treatment and employment service is integrated in a single client chart. EC helps the treatment team think about employment for people who haven't yet been referred to the service. EC office is in close proximity to the treatment team.
Collaboration between employment specialists and key staff members in government income support and labour market programmes	Liaison is important to promote sufficient referrals and to obtain assistance with income support and other return-to-work assistance. The ECs and related programme staff have frequent contact with Work and Income staff and PATHS staff for the purposes of identifying potential referrals, discussing shared clients, and obtaining additional assistance.
Work incentives planning (financial / benefits)	All clients are offered assistance in obtaining comprehensive individualised work incentives planning before starting a new job and assistance accessing work incentives planning thereafter when making decisions about changes in work hours and pay. Clients are provided information and assistance about reporting earnings to Centrelink (Australia) or Work and Income (New Zealand), and any other programme e.g. Housing, Veterans Affairs, that needs to know the new income details.

Source: Australian and New Zealand Supported Employment Fidelity Scale, Version 2.0. (2011)

3.2 Political and social drivers

In 2007, Workwise made its first attempt to expand their employment support services into general practice through a 12-month trial. The trial enjoyed partial success, but proved unsustainable at the time. Workwise identified a range of factors that constrained success, including the immaturity of the primary health organisation service delivery model (leaving GPs wondering "what is in it for us in offering services such as employment support"), the predominance of conventional biomedical thinking amongst GPs (e.g. "employment is not really a health issue"), and the lack of policy and funding support for integrated services. Consequently there were too few referrals to justify the employment support resource provided. The social and health policy in New Zealand has shifted significantly since 2007 and many of the challenges the employment support and health services faced then have changed.

In the past decade mental health care has been shaped by the development of a recovery philosophy that underpins service delivery and practice and the recognition that social and economic factors, such as employment, housing and poverty, all impact on mental health, wellbeing and recovery. Coupled with an understanding of how essential it is that all parts of the state sector, and wider community services, work together across traditional boundaries to provide services.

These developments indicate that it is now appropriate and timely to apply the principles of EBSE in primary care. Particular social and political factors supporting this view include:

- people who experience mental health conditions want the same things in life as everyone else
- interest in the health benefits of work is growing amongst clinicians in New Zealand
- the increasing role of primary care and GPs in the provision of mental health care
- the second phase of welfare reform policy, coming into effect in July 2013, aims to target resources at people most at risk of long-term welfare dependence and support people who can work, back to work
- the role of employment advisors as part of mental health and addictions services is now a workforce development priority for the Ministry of Health.

These factors are themselves potential enablers to the implementation of the Hamilton demonstration project and are therefore described in more detail below.

People with mental health conditions value the same things in life

People who experience or have experienced a mental health condition still value the same things in life as everyone else – to live freely, have friends and colleagues, and to be productive (Drake et al., 2012). Surveys of people with mental health conditions typically show most people would like to work, and see employment as a central part of their recovery (Beynon & Tucker, 2006; Mental Health Commission, 2012). Aspirations are especially high for young people who wish to stay in employment or education, but are also high amongst older people who may never have worked or who have had a long time out of the workforce. For many however, periods of unemployment will have lowered confidence levels and self-esteem. The role of the health professional is therefore critical. Clinicians are crucial carriers of hope and expectation about return to work, and need to ensure they do not perpetuate a negative cycle of hopelessness (Marwaha, Balachandra, & Johnson, 2008).

Many people view their GP as a first point of contact when health problems arise. They trust their advice and guidance. Research from New Zealand and internationally suggests about a third of people who consult GPs have a mental health problem or illness at the time of the consultation, or have experienced one in the past year (Oakley Browne, Wells, Scott, & McGee, 2006; The MaGPIe Research Group, 2002). GPs are well-placed to pick up problems at the earliest possible time, to ask about employment status and to offer the necessary treatment to prevent some problems becoming more severe. They can assist people to manage and recover from mental health conditions, and to stay at or return to work. In general, people begin to consult their GP more frequently for mild mental disorders two to three years prior to claiming incapacity benefits (Whittaker et al., 2010). GPs

can use this window of opportunity and interrupt the progression of mental ill health to long-term welfare dependency (Fergusson, Boden, & Horwood, 2007a).

The health benefits of work and health risks of unemployment

With the now unequivocal evidence on the interrelationship between health and work, New Zealand health professionals are showing a growing interest in the health benefits of work and their role in ensuring patients access these benefits as well as the harmful effects of unemployment. Many of the Australasian and New Zealand colleges, including the Royal New Zealand College of General Practitioners and the Royal Australian and New Zealand College of Psychiatry, demonstrated their support by signing the 2011 *Australasian Faculty of Occupational and Environmental Medicine Position Statement on Realising the Health Benefits of Work* (The Royal Australasian College of Physicians, 2011). Furthermore, in 2012 several New Zealand clinical conferences, including those hosted by the Royal Australian and New Zealand College of Psychiatry, the Royal New Zealand College of General Practitioners and the New Zealand Society of Occupational Medicine, featured presentations and workshops on mental health and work.

In addition, the Medical Council of New Zealand have recently updated the good practice doctors' guidelines to include a standard on talking to patients about work (Medical Council of New Zealand NZMC, 2012) and the new general practice education programme now includes a topic on health and work (Royal New Zealand College of General Practitioners RNZCGP, 2013).

> *"Encourage your patients and the public to take an interest in their health and to take action to improve and maintain their health. Depending on the circumstances, this may include encouraging patients to stay in, or return to, work or engage in other purposeful activities" Medical Council of New Zealand, 2013*

Increasingly, doctors and other health professionals view the harmful effects of being out of work on health in the same way as obesity and smoking, recognising the negative side-effects of issuing medical certificates (Cohen, Aylward, & Rollnick, 2009; Wynne-Jones, Mallen, Main, & Dunn, 2010). Chronic unemployment is a powerful determinant of adverse health outcomes, even after adjusting for confounders like the presence of a mental disorder. At a population level, socioeconomic factors contribute as much to health outcomes as health factors (Blakely, Collings, & Atkinson, 2003; Fergusson et al., 2007a; Fergusson, Boden, & Horwood, 2007b; Li, Page, Martin, & Taylor, 2011).

Unemployment rates differ across ethic groups. For example working-age Māori have three times the chance of being long-term welfare beneficiaries (on benefits over 12 months) compared with working-age non-Māori. The same inequalities exist for Pacific people of working age, who are twice as likely to be long-term welfare benefit recipients, compared to non-Māori and non-Pacific people of working age (New Zealand Government, 2012; Statistics New Zealand, 2011). This means that addressing long-term unemployment is also a health inequalities and an ethnic inequities issue and reinforces the imperative that primary care clinicians intervene with regard to socioeconomic factors and are able to offer interventions to support a person to return to or stay at work as part of the clinical consult.

The increasing role of primary care in the provision of mental health care

The role of primary care and GPs in the provision of mental health care and treatment in New Zealand is increasing and has necessitated significant capacity development within the sector. The second New Zealand mental health and addiction plan raised the importance of greater connectedness between primary health care providers and mental health services to achieve better health outcomes(Minister of Health, 2005). The need for primary and secondary care integration has been further directed in the recent Ministry of Health service development plan, *Rising to the Challenge* released at the end of last year (Ministry of Health, 2012). The plan describes the role of ECs, as well as the health sector, working with the Ministry of Social Development on the provision of employment support services for people with mental health conditions and / or addictions.

The change in the structure and funding of the primary health care sector, brought about by the implementation of the *Primary Health Care Strategy* in 2001, provided an opportunity to improve responsiveness to mental health needs, as an integral part of the establishment of primary health organisations (Minister of Health, 2005).

New Zealand welfare reform and the role of GPs

In New Zealand, as in many other OECD countries, people with mental health conditions make up the largest proportion of claimants on Work and Income health and disability benefits. About 40 per cent of people receiving a sickness benefit have a psychiatric or psychological issue as their primary reason for making the claim (Beynon & Tucker, 2006; Ministry of Social Development (MSD), 2012). In addition people who have been out of work for more than six months for reasons unrelated to their mental health increase their risk of developing a mental health condition (Waddell & Burton, 2006).

The proposed welfare reforms place a greater emphasis on supporting people who can work to transition into work, and on investing in people who have a greater risk of becoming long-term welfare recipients. The government's aims behind the new approach are to better understand the abilities of people who are receiving benefits and ensure people do not stay on benefits longer than they need to. Additionally the government seeks to increase the profile of the value of paid employment, particularly in relation to recovery and long-term management of many health conditions or impairments.

Due to the prevalence of mental health conditions in people with are long term benefits claimants, for welfare reform to be effective, health and vocational support services need to be coordinated (Waddell, Burton and Kendall, 2008).

Yet the current focus within the welfare system is on the GP's role in relation to the provision of medical certification, rather than the importance of return to work as a health outcome.

Literature indicates that GPs often experience a tension between protecting the doctor-patient relationship and encouraging patients to return to work. Anecdotally, New Zealand GPs experience similar tensions. While many GPs understand the health benefits that work provides, others still have misconceptions that the patient is too

sick to work or can't cope with work stress (Hunter Institute of Mental Health, 2008). GPs who want to encourage their patients to return to employment face barriers due to the labour market, a lack of employment support services or feeling that their patient would be unable to navigate the complex benefit system (Hunter Institute of Mental Health, 2008). Some GPs have indicated that they are frustrated by a lack of ongoing communication from some service providers, including Work and Income, and worry that their patients will "fall through the cracks" after transitioning off the sickness benefit and end up in worse health or that unrealistic obligations to find work will be put on a patient, should their doctor certify them as fit for work (Coggon & Palmer, 2010; Thomson & Hampton, 2012).

In response to the need to complete a medical certification and the absence of an alternative option, GPs can find themselves prescribing further time out of work as a treatment for people who have ill-defined barriers to work, a process that seems to go against the "first do no harm" principle (Gillon, 1985).

Employment advisors in mental health services are a workforce development priority

In December 2012, the Ministry of Health released *Rising to the Challenge,* the mental health and addictions service development plan for 2012 to 2017 (Ministry of Health, 2012). The purpose of *Rising to the Challenge* is to set the direction for mental health and addiction service delivery across the health sector over the next five years. It sets this direction through articulating Government expectations about changes needed to build on and enhance the gains made in the delivery of mental health and addiction services in recent years (Ministry of Health (MoH), 2012).

The plan is clear about the importance of increasing education and employment support for people who experience mental health conditions. The numbers of people in employment and education is a new district health board accountability measure:

- "Increase in employment and education opportunities for people with low prevalence conditions" (MoH, 2012, p. 24).
- "Employment specialists are a priority area for re-direction of resources and future workforce development" (MoH, 2012, p. 27).

The service development plan complements the recommendations in *Blueprint II* (Mental Health Commission, 2012) and Health Workforce New Zealand's Mental Health and Addictions workforce service review report (Kydd et al., 2011). These documents, both released in the past 18 months, also call for an increase in employment support for people with mental health issues. They emphasize the need for employment support in both primary and secondary mental health services.

4. Evaluation approach and method

While EBSE has been rigorously evaluated in secondary mental health services, primary care and general practice in particular, provides a new implementation context for the intervention. For this reason, a programme of evaluation comprising two phases is being conducted alongside the demonstration programme. Phase one this formative evaluation, phase two a process and outcome evaluation.

The following section describes the aim and objectives of the formative evaluation, key evaluation questions, the evaluation approach, and the methods used to collect and analysis the evaluation data. Limitations of the evaluation are identified.

4.1 Evaluation objectives

The Hamilton demonstration programme is the first of its kind in New Zealand to apply the principles of EBSE in primary care. A formative evaluation was therefore initially conducted to clarify the initiative's feasibility and acceptability to stakeholders, understand the programme's establishment and early implementation, and to provide direction for the ongoing development of the programme.

The objectives of the evaluation were to:

- understand and document the initial set up and implementation of the demonstration programme (first six months)
- examine the feasibility of applying the principle of integrating employment support with clinical treatment in a primary care setting and describe what that looks like
- establish and agree the required data and data collection methods for phase two of the evaluation
- provide information to inform the ongoing development and implementation of the demonstration, and inform the development of further employment programmes in other sites.

Key evaluation questions examined in relation to the evaluation objectives included the following.

- What are critical factors to successful implementation and what are the challenges?
- What are the effects on clinical practice of integrating ECs?
- What factors in the primary care context may influence EBSE processes and outcomes?
- What incentives and disincentives exist for GP participation in employment support services that follow EBSE principles?

Given the developmental focus of the formative evaluation, it should be noted that patients who received employment support services during the first year of the demonstration programme's implementation were not directly involved in the formative evaluation as participants. Patients' experiences and perceptions of the programme, as well as the impact of and outcomes from the programme on them, would benefit from direct examination in phase two of the evaluation.

4.2 Evaluation approach

The evaluation approach adopted to conduct the formative evaluation drew on the evaluation and research traditions of theory-based evaluation, realistic evaluation, naturalistic inquiry and responsive evaluation. These approaches are appropriate to the developmental and learning focus of formative evaluation, and guided the framing of the evaluation questions, as well as methods chosen to collect and analysis the evaluation data.

A brief description of each evaluation approach and how it shaped the evaluation approach follows.

Theory-based evaluation

A theory-based evaluation approach (Chen, 1990; Funnell & Rogers, 2011) builds from understanding how interventions are expected to work, that is, how the activities and mechanisms of an intervention are expected to lead or contribute to intended outcomes (i.e. the programme's theory). Mapping how an intervention is expected to work, including how intermediate outcomes lead to longer term outcomes, guides the development of appropriate evaluation questions, as well as the identification of criteria for assessing quality (how well was the intervention designed and delivered) and success (what outcomes occurred and with what impact). Critically, the programme theory provides a framework that enables evaluation to fulfil a diagnostic function (e.g. why is a programme working or not working as expected), rather than just simply describing whether or not the intended outcomes were achieved.

The evidence base for EBSE and the fidelity scale used to determine fidelity, provide the theory underpinning employment support programmes that follow EBSE principles. The EBSE principles and scale, therefore, provide an existing framework for determining evaluative questions regarding the quality and success of the demonstration programme. The quality review of the demonstration, undertaken as part of this formative evaluation, and based on the EBSE fidelity scale, provides an initial assessment of the extent that the programme is aligning to EBSE principles and what this is starting to look like in primary care.

An initial, draft outcome chain for the demonstration programme was developed by the evaluation team to help guide the evaluation design in the manner described above (see Appendix B). An outcome chain comprises part of a programme theory. It specifies how change is expected to occur by showing assumed causal relationships between different outcomes, often displayed in assumed temporal order (i.e. short, mid-term, longer-term) and read as a series of if-then relationships (i.e. if outcome A then outcome B, if outcome B then outcome C etc.). The outcome chain was informed by the evaluation team's understanding of the EBSE literature, the programme evaluation and other relevant literature, for example, on programme implementation and management (Boyce et al., 2008; Roh, 2012; Wandersman, 2009; Wichita State University, 2011), and on rehabilitative and therapeutic change (Sainsbury Centre for Mental Health, 2007)

Development of programme theory is ideally a collaborative process that draws on the views and experiences of key stakeholders. It should be noted that, while the initial outcome chain developed for this evaluation was not the result of widespread collaboration, it proved to be a sufficiently useful and credible draft to shape aspects of the formative evaluation design (e.g. informant selection) and the intent of the evaluation questions.

The outcome chain was later redeveloped in the process of presenting key findings to a stakeholder workshop, and is expected to be developed further in phase two of the evaluation and as part of developing the programme theory of the demonstration.

Realistic evaluation

A key aim of the overall evaluation of the demonstration programme is to understand how the context of general practice interacts with the mechanisms by which EBSE works, and to determine whether and how EBSE works in this context. Realistic evaluation (Pawson & Tilley, 1997) provides a theory-based evaluation approach for addressing such questions. It provides an evaluation framework for examining how the intended or assumed working mechanisms of an intervention interact within different contexts and how these interactions determine how interventions work.

The focus is on examining the context, mechanism and outcome relationships (called CMO configurations) that exist, and how these explain intended or unintended outcomes. The nature of these relationships will be influenced by context; in the case of the demonstration programme, the primary care context. Therefore, rather than asking 'Does this programme work?', realistic evaluation asks 'What [aspects of a programme] work, for whom, and in what circumstances.' Answering these questions will be important in phase two of the evaluation, when the focus will be more on determining outcomes from the demonstration programme and how these have been influenced or moderated by the primary care context.

In preparation for addressing realistic evaluation questions in phase two, the evaluation team undertook some initial modelling of how the primary care context might interact with the assumed working mechanisms of EBSE to determine outcomes (see Appendix C). These models should again be considered initial working drafts, to be developed further through stakeholder input in phase two.

Naturalistic inquiry

Rather than describe a specific evaluation methodology, naturalistic inquiry is best understood as providing a model for conducting evaluation based on certain assumptions regarding the nature of social phenomena (Guba & Lincoln, 1982). A naturalistic inquiry approach is appropriate for formative evaluation, as it supports evaluation as an exploratory process that examines multiple experiences and perspectives. The approach acknowledges that interventions exist and interact within wider contexts, and that these interactions must be understood to understand how programmes work and their outcomes. The approach is therefore appropriate for examining the contextual questions of interest in this evaluation. Under the approach, qualitative methods are typically used to provide in-depth and contextualised understanding of the evaluand and of stakeholder perceptions, experiences, and outcomes. A qualitative approach is in general appropriate for evaluating new, emerging programmes and for providing developmental guidance.

Responsiveness evaluation

Responsiveness evaluation (Stake & Abma, 2005) pays particular attention to programme activities and what actually happens (rather than what was intended to happen); is responsive to audience information needs (similar to a utilization-focused approach), and examines programme achievements from different standpoints. A responsive approach requires the evaluation team to ensure that the evaluation questions and findings provide value and utility in regard to programme and policy development. In the current evaluation, the cross-organisational evaluation team helped to ensure that the team were cognisant of meeting different stakeholders' information and decision-making needs. These varying, but complementary, interests included the following.

- The Te Pou evaluators had interests in the general establishment and development of the programme, including need and relevance, early implementation and uptake, unintended consequences, unforseen opportunities and early outcomes.
- The Wise Group evaluator was particularly interested in checking the feasibility of fidelity principles translating from secondary care settings to primary care, and the implementation of evidence-based practice at both a practice and policy level.
- The Ministry of Social Development researcher was concerned with understanding GP engagement with employment support, patient uptake and Work and Income's prospective role in supporting this.

4.3 Evaluation method

The following section describes the mixed methods used in this evaluation to collect, analyse and report on the evaluation data.

Data collection methods

The data collection methods used included a brief literature review, in-depth interviews, the review of routine programme data, a stakeholder workshop, stakeholder consultation (routine programme data) and an initial quality review using aspects of the EBSE fidelity scale.

Literature review

A brief review of the EBSE literature was conducted to inform the evaluation design. The review was primarily conducted as an internal working resource and was not developed to a standard appropriate for publication or wider dissemination.

In-depth interviews

A series of in-depth face-to-face interviews were conducted by the evaluation team with key stakeholders during August 2012. The implementation steering group advised the evaluation team on appropriate stakeholders to interview, and supported and endorsed the recruitment process.

Interviews were conducted with representatives from all key stakeholder organisations, as well as with Workwise staff working in the demonstration programme. Interview participants included eight GPs, three representatives

from the Midlands Health Network, two senior managers from Workwise, two ECs working in the programme and two representatives from Waikato Work and Income.

All interviews were conducted following semi-structured interview topic guides (see Appendix D for the topic guides). Each guide was tailored, as appropriate, to each of the stakeholder groups interviewed. Interviews ranged between 15 minutes to one-and-a-half hours, with the GPs generally only able to participate in the shorter interviews. Each interview was conducted at a time and place that was convenient to each participant, generally their place of employment. All interviews were audio-taped and fully transcribed to facilitate data analysis.

Review of routine programme data

Recordbase is the data collection and management system used by Workwise to record all programme and client data generated in the demonstration programme. Data for each patient referred to the employment support programme is recorded by the ECs throughout that person's involvement in the programme. Data providing initial descriptions of programme activities and early employment outcomes from the first 12 months of the programme are reported in Chapter 8.

Stakeholder workshop

A 4-hour participatory, sense-making workshop was held with the implementation steering group on 13 September 2012, to discuss and further interpret emerging findings from the evaluation. The workshop comprised a series of visual presentations prepared and presented by the evaluation team on distinct areas of findings from the evaluation. The findings were then discussed and the analysis progressed through a series of facilitated discussions. Key areas of emerging findings examined included the primary care context for EBSE (key differences compared to secondary care, success factors to EBSE, challenges), the initial establishment and implementation of the programme, and the initial performance of the programme in relation to EBSE fidelity. Issues to address and future programme developments were discussed.

Throughout the discussion, the following prompts were used to facilitate participants' reflections on the emerging data.

- Do these findings or issues confirm existing understanding?
- Are these findings or issues surprising or new for members?
- Can members provide further background or understanding that would help extend the understanding or meaning that could be drawn from these findings or issues?
- What else has happened or is happening that addresses or is likely to address these findings or issues?
- What are the implications of these findings or issues for further development of the project – immediate development and longer term?
- What information or understanding is missing – how might we address this in the evaluation?

Quality review

An initial quality review of the demonstration programme against key aspects of the Supported Employment Fidelity Scale was undertaken during August 2012. Research shows that employment services that regularly review their practices against the evidence (fidelity review) achieve better employment outcomes.

A comprehensive fidelity review typically consists of a 1-to-2-day visit to the programme by two experienced reviewers to observe practices and understand service processes. Interviews are conducted with all staff, as well as with clients and patients. The process is strengths-based and designed specifically to support the service to achieve better outcomes for clients and patients. A report is provided which scores the programme on all 25 items of the scale and makes recommendations against each item for better alignment to the evidence.

Given the early implementation and developmental phase of the demonstration, and the formative evaluation, a full fidelity review was not undertaken in the first 6 months of the programme. However, as the evaluation team was conducting key stakeholder interviews around this time, fidelity questions were incorporated into these interviews. To support the review process, a member of the evaluation team with previous experience of conducting EBSE fidelity reviews co-facilitated five of the interviews that were conducted. Relevant data generated from the interviews was used to provide an initial quality report and a list of service development recommendations in relation to fidelity (see Section 7 of this report). Given that the process undertaken constituted a partial, rather than full, fidelity review, scores were not provided against all 25 items in the fidelity scale, nor was an overall fidelity score provided. Rather, the focus of the process was on providing direction for further programme developments, in accordance with key EBSE principles and processes. Table 1 below shows the aspects of the fidelity scale that were directly addressed through the process described above.

Table 2: EBSE fidelity scale items addressed in formative evaluation interviews with stakeholders

Fidelity scale item	Brief description
2	Employment services staff
4–5	Integration of employment support with mental health treatment
8	Role of employment supervisor
9–10	Zero exclusion and a focus on competitive employment with client self-direction
11	Executive team support for supported employment
12	Financial planning

Stakeholder consultation (routine programme data)

The evaluation team consulted extensively with Workwise staff to understand Recordbase, the data collection and record keeping system used in the demonstration programme. A core goal was to understand the utility and

availability of the routine data collected within the programme, for the purposes of the evaluation. As a result of this inquiry, a small number of additional measures were identified and negotiated with Workwise to be routinely collected within the demonstration programme and recorded in Recordbase.

As an output under the objective to determine necessary data collection under phase two of the evaluation, an initial framework was developed showing available Recordbase data and how it will be potentially used within the evaluation (see Appendix F). This framework will be developed concurrent with further development of the process and outcome evaluation objectives, methodology and methods.

Data analysis method

The following section describes the methods used in this evaluation to analysis the evaluation data collected.

Analysis of qualitative data

The qualitative data generated through the in-depth interviews was analysed using thematic analysis (Braun & Clarke, 2006). Thematic analysis provides a systematic process for identifying patterns, themes and meanings within qualitative data, through data coding at conceptual and higher categorical levels. Codes are used to describe and assign meaning to data. Code frames, derived initially from the evaluation objectives and questions and preliminary programme theory, were developed and provided the structure for coding decisions and the coding process overall. For example, distinctive codes were developed and organised under higher categories to describe the range of enablers and barriers to satisfying the EBSE principle of integration within primary care that were identified.

The analysis was performed using both NVivo (qualitative data management and analysis software) and Microsoft Excel. Attention was paid to ensuring the full range of perspectives and experiences reported by stakeholders during the interviews was captured through the analysis. Similarities and differences within the data, including outliers (infrequent findings that are none-the-less theoretically significant), were identified. Attention was paid to identifying any data that indicated programme development and performance in accordance with expectations (e.g. as articulated through EBSE principles and the draft outcome chain). Quotes that added explanatory power or cogently illustrated key findings were selected for inclusion in the stakeholder workshop and this report.

Analysis of quantitative data

The formative evaluation undertook limited secondary analysis of the available routine programme and client data for the period of the demonstration programme covered in this report. Data presented in Chapter 8 provides a description of the initial programme activities and outcomes.

Limitations of the evaluation

There were limited resources available for the overall evaluation of the Hamilton demonstration programmes, and the scope and ambition of the evaluation have been established accordingly. Resource constraints inevitably impact the design, conduct and utility of most evaluations and the current evaluation is no exception to this.

The reader should observe that the evaluation findings presented in this report have been derived primarily from a limited number of key stakeholder interviews, the quality review and the stakeholder workshop. Where possible, this data has been triangulated with available routine programme and client data from the programme so far. The evaluation approach, including data analysis and reporting, has been informed by a desk-based review of the EBSE literature, as well as the evaluations team's ongoing contact with the programme and engagement with key staff and other stakeholders.

The evaluation team acknowledges that the data sources and data used in the formative evaluation are limited. In line with the developmental and learning-orientated objectives of formative evaluation, the reader should recognise this evaluation report provides just one input into developing an ongoing understanding of the programme and its future implementation.

5. Programme establishment

This section provides an initial overview of the demonstration programme and describes how it was established. It also considers the key enablers and challenges, identified by stakeholders, to the establishment process.

Enablers include:

- the employment provider's track record and experience
- a shared common interest between stakeholders
- timely and flexible funding streams
- face-to-face programme introduction
- the general practice environment
- organisational leadership.

Identification of these factors provides guidance on supportive conditions for establishing similar programmes at other sites in the country and for extending the current programme.

5.1 Programme overview

The primary care employment support demonstration programme is a partnership between Workwise and Midlands Health Network that commenced on 1 February 2012 and is set to continue until June 2013. The programme is focused on helping people with mental health conditions being treated through primary care to obtain, return to, or keep their existing, employment.

The employment support is provided within general practices at no direct cost to the patient, the GP or the practice. The GPs continue to provide usual health treatment for patients.

The dedicated ECs work collaboratively with GPs to support patients. In particular, the ECs:

- pick up the referral, contact the patient to complete the referral process and set up a meeting
- assess the patient's psycho-social fitness to work, which involves exploring with them their employment goals and potential barriers to work
- carry out back-to-work planning, in consultation with the GP, which involves developing a return-to-work plan
- provide benefits advice, guidance and liaison with Work and Income services
- as agreed with patient, provide feedback to the GP
- liaise with GPs about emerging health issues during the course of the patient's employment
- communicate with employers and actively develop jobs as well as respond to vacancies
- provide direct and ongoing support to patients to obtain, maintain or resume employment.

The demonstration programme is being overseen by a steering group consisting of representatives from Midlands Health Network, Workwise and the evaluation team, with initial additional representatives from

Waikato Work and Income. The service is provided by Workwise, a non-government not-for-profit organisation.

Target group

The eligible target group for the demonstration project (from August 2012) was:

- people whose key barrier to employment is a mild-to-moderate mental health condition
- people at risk of losing their employment, because of a mild-to-moderate mental health condition.

Initially, and until the end of July 2012, the eligible target group was also required to be receiving a Sickness Benefit or Invalid Benefit. This was associated with funding received from Waikato Work and Income that came to an end on 31 July 2012.

Programme location and implementation

The employment support programme is based in a group of urban Hamilton general practices and is being implemented in a two-staged approach. The first stage of implementation was in three general practices (the NorthCare model of care sites). These were followed in the second stage (later in 2012) by a further two practices that are not using the model of care but have an enrolled patient population with high levels of deprivation[1]. Following initial start-up funding from Waikato Work and Income, the Wise Group is now funding the demonstration phase, which includes providing up to two full-time experienced ECs to enable implementation of the programme.

The three NorthCare medical centres are located at Pukete Road (Site A), Grandview Road (Site B) and Thomas Road (Site C). The ECs are physically located within Site A, and are mobile and readily accessible to enrolled patients and their GPs at Sites B and C. These sites were selected based on the practices' extended general practice team ethos, which enabled co-location of other service providers. The demonstration programme aims to work with between 80 and 100 people across the three sites between February 2012 and June 2013..

Population of the demonstration programme

The total enrolled population of the three medical centres involved in the first stage of the demonstration is 15,649 patients. The following table describes the centres in more detail, including statistics from the 2006 Census data on the population diversity and unemployment rates within the localities where the practices are located. The enrolled patient NZ Deprivation profile, from each of the practices, is also provided.

[1] These further two practices were not part of the programme when the formative evaluation took place and are therefore not included in this evaluation report.

Table 3: Summary of statistics from the demonstration programme sites

	Site A	Site B	Site C
Medical centre staff	Eight GPs, six nurses, two medical centre assistants, (a mix of part-time and full-time staff), primary mental health coordinator	Three GPs full time, three nurses, one medical assistant, primary mental health coordinator	Four GPs, three nurses, one medical assistance (a mix of part-time and full-time staff), primary mental health coordinator
Overview of caseload[2]	Based in the middle of an industrial area, treatment caseload for workplace accidents and emergency care is high, as well as treating the families in the area	A Very Low Cost Access site, the prices are set lower than the other two sites and the centre is "practically filled to their books". Highest numbers of Māori/Pacific patients	Centre is located in a new up-and-coming area, with many young families. Treatment caseload reflects family needs
Cultural diversity[3] of catchment sub-locality	74.9% European 10.8% Māori	66% European 22.8% Māori	72.1% European 7.6% Māori
Unemployment rate[4] of catchment sub-locality	3.8% for people aged 15 years and over	5.9% for people aged 15 years and over	2.5% for people aged 15 years and over
Enrolled patient NZ Deprivation Profile[5]	Quintile 1 & 2 (lowest deprivation)	Quintile 4 & 5 (highest deprivation)	Quintile 1 & 2 (lowest deprivation)

As outlined in the table, while the sites were all part of the NorthCare model of care, there were a number of differing characteristics, with patients from Site B experiencing the highest levels of deprivation and unemployment rates and the greatest proportion of Māori patients in the catchment locality.

The differences in the sites and any potential impact that this has had on the integration of the employment programme to date, is explored in Chapter 6.

[2] Anecdotal evidence reported by the practice manager

[3] Statistic New Zealand 2006 Census data

[4] Statistic New Zealand 2006 Census data

[5] Midlands Health Network. (2012). *Hamilton City population health and service profile.* Hamilton: Midlands Health Network. Available at: www.midlandshn.health.nz/uploads/mhn-enrolled-population-health-and-service-profile.pdf

5.2 The establishment process

To better understand the setup of the demonstration programme, the establishment milestones have been mapped out in a timeline in Table 3 below. The milestones which were specifically identified by the stakeholders are then discussed in more detail afterwards.

Table 4: Establishment milestones

	Milestones
Jun 2011	Workwise receives $75K one-off funding from Work and Income (Disability Employment Innovation Fund)
Jul 2011	First meeting between Workwise chief executive and Midlands Health Network chief executive
Jul to Nov 2011	Midlands Health Network gains agreement from its management team and clinical governance group
Jul to Dec 2011	Waikato Work and Income refers 30 short-term Sickness Benefit clients directly to Workwise, while Midlands Health Network GPs build their referrals
Dec 2011	A memorandum of understanding is signed between Midlands Health Network and Workwise to establish the employment support demonstration programme
1 Feb 2012	Employment support demonstration programme begins at the NorthCare model of care sites
May 2012	Te Pou begins evaluation of demonstration programme
May to July 2012	Workwise and Midlands Health Network negotiate with three East Hamilton GP-run medical centres to expand programme
July 2012	Work and Income funding ends; The Wise Group commits to providing ongoing funding
Sept 2012	Both ECs have near full caseloads from GP referrals

Agreement between Workwise and Midlands Health Network

In mid-2011, the Wise Group started discussions with Midlands Health Network's chief executive around the idea of integrating ECs into general practices.

> *The chief executive of Midland Health Centre was the first person that we approached. We discussed it and I presented a brief around employment as a health intervention from a mental health perspective and secured his agreement to look at integrating employment consultants within Midland… the timing was right for that work particularly with the NorthCare model of care sites.* (Representative from Workwise)

Further discussions took place at an operational level to develop a formal memorandum of understanding.

> *The next stage requires everybody operationally being on board, like the team leaders, practice managers, service manager…all of those conversations help to shape the role I play and indeed the memorandum of understanding.* (Representative from Workwise)

This agreement and involvement of leaders at both strategic and operational levels were viewed by stakeholders as an important foundation to the creation of the memorandum of understanding, the evolution of the relationships with Work and Income, and the establishment of the demonstration programme.

Agreement with Work and Income

Waikato Work and Income contributed funding for the establishment phase. Two representatives from Waikato Work and Income – the planning and funding manager and the health and disability coordinator – were initially involved with the programme steering group. The health and disability coordinator was the main liaison person for the steering group, providing an operational focus, and was able to assist with troubleshooting during the establishment and implementation phases. This was in addition to their liaison and advisory role between the general practices and local Work and Income offices.

The two Work and Income representatives assisted in the site selection process. They indicated a preference for choosing sites that would serve the greatest number of patients receiving sickness benefits.

Site selection

The implementation steering group identified two priority criteria for site selection: a general practice team ethos that enabled co-location of, and collaboration with, other service providers; and general practices serving high numbers of people who are out of work. Seven sites were considered and investigated.

The NorthCare model of care practices has the largest number of enrolled patients among the seven potential sites looked at. While the population enrolled in these sites did not meet both priorities identified by the steering group, they were selected on the basis that their shared model of practice was best aligned with the principle of integrating employment support and, therefore, the best positioned to allow Workwise to test its experiential knowledge and provide early understandings about how integration could work in general practice.

5.3 Enablers to establishment

This section discusses factors that supported and enabled the establishment of the demonstration programme at an organisational level. Identification of these factors provides guidance on supportive conditions for establishing similar programmes at other sites and for extending the current programme.

Provider's track record and experience

Workwise's track record of providing locally and their capability was seen by Waikato Work and Income as an opportunity to work with a trusted provider to test out a new way of working and was a clear lever for accessing the initial funding.

> *We support early intervention as a principle...we were [therefore] very supportive of the idea. It was a small amount [of funding for] a trusted provider to give them the opportunity and leeway to put something together…one of the things that I've enjoyed has been Workwise, knowing that there is a substantial*

organisation and their focus is working effectively with people [with mental health conditions]. (Representative from Waikato Work and Income)

Workwise has provided employment services aligned to the principles of EBSE in mental health services throughout New Zealand for over 10 years. Workwise ECs are currently integrated in approximately 55 different multidisciplinary health and welfare environments across several regions. By following the evidence closely in these environments, Workwise is achieving results in employment services that place them in the upper quartile internationally (Browne, Stephenson, Wright, & Waghorn, 2009; Waghorn, Stephenson, & Browne, 2011).

Having successfully secured the support and financial investment from Waikato Work & Income, Workwise were able to meet with MHN's Chief Executive to present the idea of the programme. It was clear from talking to stakeholders that this process had been very positive and engendered committed senior leadership.

[Workwise] had just made contact with [CEO] and said "look I've got this concept and what do you think?" and [the CEO] thought it was a good idea. (Representative from Midlands Health Network)

In addition Workwise's previous experience running integrated employment support programmes meant they had a wealth of experiential knowledge to draw from and apply to the general practice setting. They reported how they were able to identify factors which were likely to support an integrated programme and ensure they were in place. These included, settings that enable cross-disciplinary work, a team ethos, and practices with a holistic attitude to health, particularly addressing the social determinants of health and committed to work ing with the ECs so that they feel part of the team.

What's really important is that there is a relationship between one consultant and each centre so that they are seen as part of that team…and that primary care team sees them as part of them, they belong to them and they are their resource…that's really important. (Representative from Workwise)

A shared common interest

From the interviews with representatives from Waikato Work and Income, Workwise and Midlands Health Network it was clear that the three partners came together with excitement and commitment. Although they came with different priorities they had a shared common interest – to establish the first integrated employment support programme in a primary care setting in New Zealand to support people with mental health conditions to gain employment. It is this shared overall objective that is likely to have contributed to the feasibility of getting the programme off the ground. Figure 2 on the following page shows the priority area of each of the three organisational stakeholders and demonstrates how they intersect in a common goal of establishing the employment support demonstration. The three partners had complementary and interrelated interests, skills and experience, and the demonstration provided an opportunity to identify and build upon these. For example, Workwise's track record of employment support for people with mental health conditions, Midlands Health Network's new model of care to improve population health, and Work and Income's knowledge of where the greatest concentration of need is and its ability to provide upfront investment.

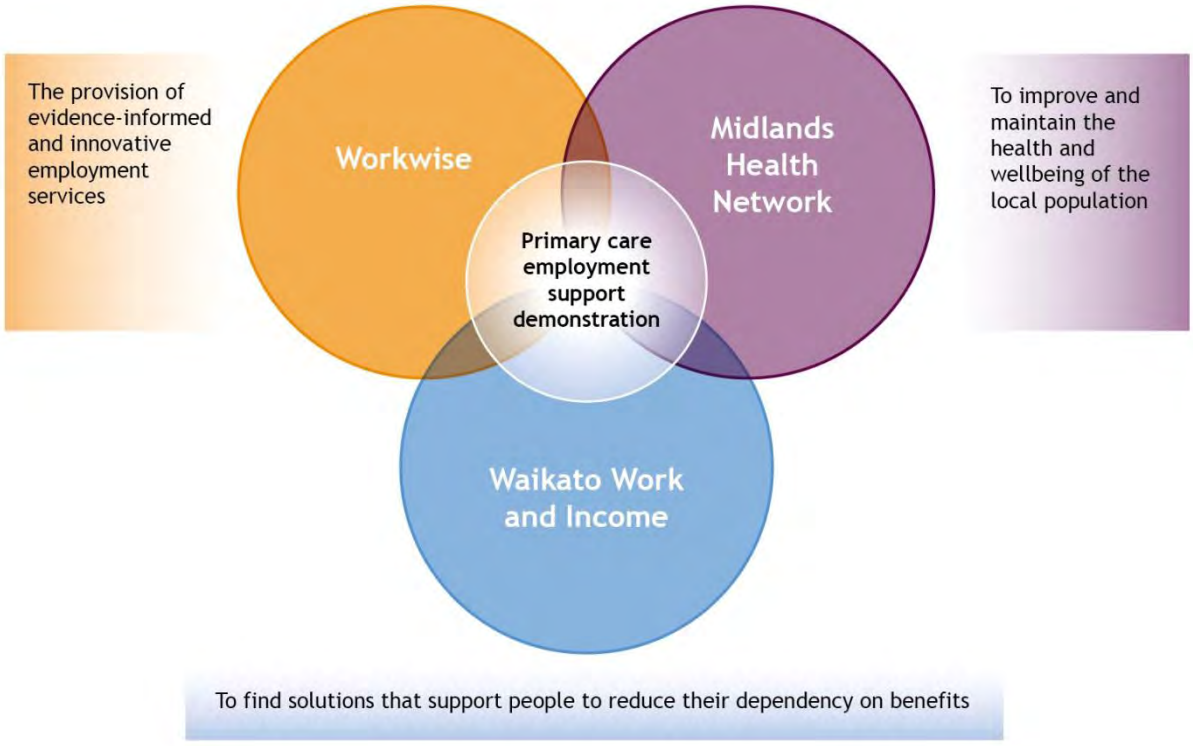


Figure 2: Summary of intersecting stakeholder interest in the demonstration

Stakeholders understood the added value opportunities presented through the demonstration and its integrated model of service delivery.

> *There's lots of golden opportunities to make a real difference because part of the problem we have, not just in health but across the sectors, is that you've got multiple resources being provided to the same people via multiple organisations or sectors and probably half the time nobody knows what the other half is doing. So it was really just about creating a climate where it was going to be easy for that stuff to happen.* (Representative from Midlands Health Network / NorthCare practice)

> *We now know that you don't have to be free of symptoms to return to work. The old thinking was that people had to get better first. If people want to return to work we need to be encouraging them to do so. These conversations can start in the GP surgery.* (Representative from Workwise)

However, the following quote from a Workwise representative indicates that establishment wasn't without challenges, and that stakeholders had to work together to find ways to align their various interests and priorities.

> *When we were first talking about this we were asking…how are we going to fund a worker to be an employment consultant… Work and Income regionally came up with some money at that stage…there was a concern that money contractually was not shaped for primary care…we [therefore] took a wider*

approach to include sickness beneficiaries referred by Work and Income as well as [people referred from] the GPs. (Representative from Workwise)

Timely and flexible funding streams

Initial funding received from Work and Income contributed to the establishment of the demonstration programme, enabling it to set up operationally until a primary care site could be selected and further funding identified. This funding was identified as both an enabler, in that it got the programme underway, but also a constrainer, in that to be eligible patients needed to also be in receipt of welfare benefits. Since August 2012, Workwise through the Wise Group, has entirely self-funded the demonstration project, as there has been no dedicated funding from government or other sources following on from Work and Income's initial grant. The strength of the Wise Group funding is that it supports the alignment of the programme to the evidence base. This alignment is demonstrated by removing the eligibility criteria restricting access to only those on welfare benefits and opening the programme to everyone who has a mental health condition and is interested in getting support to return to or remain in work. This means that the programme has been able to be more responsive to the GPs' requests to broaden patient eligibility beyond sickness beneficiaries, and consider working with people who have developed a mental health condition as a result of being out of work for a long time who may or may not be in receipt of welfare payments.

Face-to-face conversations

As the programme was an initiative between the senior leadership of the three organisations, it was important to achieve buy-in at the organisational level. To obtain interest from practice staff the steering group decided to introduce the programme to the practice in a step-wise fashion. After endorsement from Midlands Health Network to engage the NorthCare model of care sites, representatives from Workwise and Midlands Health Network attended one of the practice's morning meetings to introduce the programme to key staff. The third step was to introduce the ECs, explain their role in the programme, how the referral process worked, and how the staff could access them at a combined practice monthly meeting with staff from all three sites. Most GPs and the practice manager believed that this tailored lead-in contributed to a high level of staff understanding and buy-in.

I think it was introduced very well. We had the staff from Workwise come and meet us...they told us about the services that they provided; they told us how we could go about making referrals to them. (GPB3)

I think there was good buy-in. There was good background work, the conversations at the senior level with the PHO but then also the support and work by [senior manager] from the PHO talking to the GP surgeries. (Representative from Workwise)

Following the initial introduction, some of the GPs took it upon themselves to market the programme to other practice staff, enabling Midlands Health Network to take a step back.

> *That's the beauty of [GP involvement], you only need one or two people to feel positive about it before you get that spin off. It's the internal marketing that happens when somebody says, "Oh use that service, it's fantastic". … it's just ticking over, I haven't had a lot to do with it for the last three months.*
> (Representative from Midlands Health Network / NorthCare practice)

Reflective of this support, one GP even took the time to develop the paper referral form into an electronic form which made the process of referral much simpler.

> *So they started off with a paper form which nobody really liked because it took too long. We've (now) got a template on our software system here, we just print it off, fill it in and send it off, that's simple.*(GPB3)

General practice environment

The operating environment of the general practices appeared to contribute to the buy-in from staff. The practices are intentionally set up to enable the co-location of other providers and to provide a team approach to patient care. Site A had the physical capacity for the co-location of the ECs. In addition to the employment support programme, the practices are piloting an exercise programme, a clinical pharmacist and a mental health coordinator role, demonstrating their commitment to trialling new ways of working.

> *It was fantastic because that's the whole concept of our model of care sites, is being able to support our patients in the most appropriate way. It's absolutely wonderful to have someone to negotiate with to assist the client and negotiate with the employer and help them back into the workforce or stay working.*
> (Representative from Midlands Health Network / NorthCare practice)

As discussed, the timing in general practices was right, with more GPs taking an interest in the social determinants of health and the importance of employment to wellbeing.

> *It doesn't matter how complex their situation might be, work is still going to be good for them, if they're capable of it, which most of them are.* (GPB3)

Leadership

Senior leaders from all three partners were involved, committed to the programme, and helped to establish the steering group. This brought necessary leadership support, alignment of interests, and commitment and skills to overcome challenges as they arose.

The Midlands Health Network chief executive was supportive of the demonstration programme and dedicated senior staff to support its establishment and ongoing implementation.

> *The CEO had got excited about it, it made it a lot more achievable, so with all that level of support... from the leadership team and there's quite a lot of enthusiasm from the board about the initiatives in the early stages. Other people like the medical director, who was great in terms of looking at a target population,*

and our health intelligence team, who got all the data, [were key to the setup]. (Representative from Midlands Health Network / NorthCare practice)

Midlands Health Network was instrumental in the selection of sites and provided a senior manager to sit on the steering group overseeing the demonstration.

It's important to gain total commitment from senior leadership of an organisation. The group operated classically in a governance type role over the project but it also provided trouble shooting and operational advice as required. (Representative from Workwise)

5.4 Challenges to establishment

This formative evaluation identifies some challenges to the establishment of the programme. These include: an initial funding stream that limited access to the programme; Work and Income needing to balance a role as both funder and service operator; and rebuilding trust between Work and Income and GPs to ensure sickness beneficiaries are able to access coordinated support with work as a part of their recovery.

Eligibility and funding

As outlined, initial funding from Work and Income influenced the eligibility criteria for the programme (i.e. people with a mild-to-moderate mental health condition who were also in receipt of a sickness or invalids benefit). When the programme was established, the ECs' caseload therefore included Work and Income referred clients from prior to 1 February 2012. This limited their capacity to take on new referrals from the GPs once the programme become operational at the practice sites. The benefit criteria added to the eligibility issues that needed to be addressed by GPs and lead to some frustration for them: both at the initial lack of capacity to take their referrals, and the restricted access to employment support. As the following quotes illustrate, one GP identified patients who they believed could benefit from employment support, regardless of their benefit status.

So I've sent them some patients in the hope that Workwise would help them into some type of employment and they've said, "no sorry we can't help this person because they don't fit [the] criteria". I'm a little bit disheartened actually because basically what they're saying is, "yes it is a problem, but it's not our problem, so someone else has to deal with it, not us". I don't necessarily agree with their parameters actually. (GPB3)

So I would suggest that anybody who is currently not employed, who has the physical and mental capabilities of some form of employment, even if it means part time, even 1 hour a day, I think that I'd like to see some services put in place to try to get these people into work at least partially off the benefit. (GPB3)

Work and Income's involvement in the steering group fell away once it was no longer funding the programme. It is unclear why this support fell away as their role in this demonstration was seen as important.

Sustainable funding

The establishment of the supported employment demonstration programme stemmed from the shared vision of Waikato Work and Income, Workwise and Midlands Health Network. The strong shared vision led to the formation of a steering group that directed the initial establishment and selected the first and second stage implementation sites, based on their priority criteria. Although funding was provided through Waikato Work and Income, and later the Wise Group, both sources of funding for this programme have had limitations due to criterion for patient referrals. While removing the benefit criteria has allowed the programme to expand to support people at risk of losing their employment due to mild-to-moderate mental health conditions, GPs felt that some populations that would benefit from the service, particularly ACC beneficiaries are still excluded.

Following the above, the challenge of securing ongoing funding for the programme presents an obvious threat to its sustainability. Fidelity to the evidence base will also require a willingness to fund all necessary stages and components of supported employment. For example, client follow through (i.e. providing ongoing support once employment is secured) is critical to success.

Future funding sources for sustaining the employment support programme are being sought through conversations with both the Ministry of Health and the Ministry of Social Development, however, with no success as yet. General practices are not currently part of the funding model as the service is being provided at no charge, although there are clearly indirect costs through use of premises, printing etc. Any move to require GPs to pay for the service would need to be carefully evaluated, particularly how this might impact on their engagement with and uptake of the service.

The challenge of dual roles

Waikato Work and Income is a natural partner to this collaboration between Workwise and Midlands Health Network. It undertook an initial role as funder and, more fundamentally, as an operational partner in the delivery of employment support services to people out of work and claiming welfare benefits. Work and Income representatives indicated they were keen to learn from Workwise, particularly how to interface with primary care and purchase services from external contractors. However, one representative also identified challenges in being both a funder and operational partner.

> *As we move forward into the reform and if we start contracting in more areas that that is going to be an issue – the agency looking after our client if it doesn't know us completely and doesn't know...it's challenging being at Work and Income and it's challenging telling people, "No, we can't do that for you...", so it's almost like the way we work needs to be exposed more so that others can tap into that.*
> (Representative from Waikato Work & Income)

In summary

Despite the funding challenges identified, the overall establishment of the programme was viewed positively by stakeholders. Important enablers included strong leadership at the strategic and operational levels, a common objective across stakeholders, and working with an employment provider with experience and a track record of

success. Good leadership, a practice culture open to innovation, and an expansive model of care, facilitated buy-in among most of the GPs and other practice staff involved in the programme. Future roll out may be impacted by a practice's model of care—practices that operate under more traditional models may encounter additional or different barriers to the programme's establishment and subsequent integration.

6. Achieving integration

This section considers how the demonstration programme has responded to and addressed the evidence-based principle of 'integration of employment support with healthcare'. The role of key stakeholders in achieving integration in primary care is considered along with what integration is starting to look and how this has been achieved in the demonstration. It then discusses the factors identified as enabling and constraining service and clinical integration.

Important enablers to integration identified include:

- an EC with established professional relationships in primary care and with GPs, and experience in applying the principles of EBSE
- growing interest from GPs in the role of employment in relation to mental health
- the willingness of GPs to have employment conversations with patients
- the presence of regular prominent reminders to re-affirm GPs' awareness of work through
    - an EC regularly bring present at meetings and/or working in the same building
    - employment programme business cards visible in consulting room, and
    - high levels of patients in receipt of sickness benefits.

Indicators of good levels of integration were considered to include frequent communication (informal and formal) between the ECs and the GPs around patient care, the perception by all parties that the ECs are part of the practice team, and GPs reporting a change in their practice, particularly as regards medical certification.

The findings from this evaluation of three GP sites, alongside the body of evidence from secondary care settings, suggest that integrated employment support is enhanced through the frequent physical presence of ECs.

The findings from this evaluation of three GP sites, alongside the body of evidence from secondary care settings, suggest that integrated employment support is enhanced through the frequent physical presence of ECs. Participation in relevant team meetings is critical. Co-location in practices is optimal, but its sustainability needs further exploration. Shared record-keeping was not in place when the evaluation was conducted, but was a component of integration that stakeholders were looking to implement as the demonstration progressed.

6.1 Stakeholders and their roles

As outlined in Section 3, a full-time EC in a secondary care context is assigned to no more than two clinical teams from which they take referrals. Figure *3* below outlines the configuration of stakeholders supporting integrated employment support services in secondary mental health services. (NB: The coordination of employment support services with Work and Income is not likely to be relevant where an individual is not in receipt of government-funded welfare benefits.)

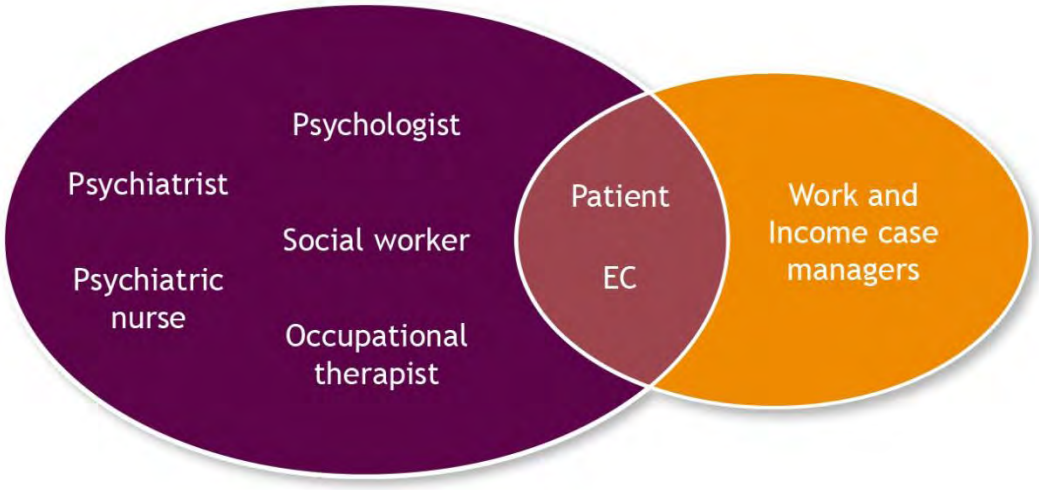


Figure 3: The configuration of stakeholders in EBSE in secondary mental health services

All members of the clinical team can refer directly to the EC. In many cases, but not all, the occupational therapist acts as an employment champion. This serves a number of functions, primarily to support the integration of the EC with the clinical team, to provide clinical supervision and to be a clinical voice for the value of employment as part of treatment.

Figure 4 outlines the key people involved in the integrated employment programme demonstration in the NorthCare sites – the EC, the GP and the primary mental health coordinator, and how the programme was established to provide a pathway of coordinated care with employment support.

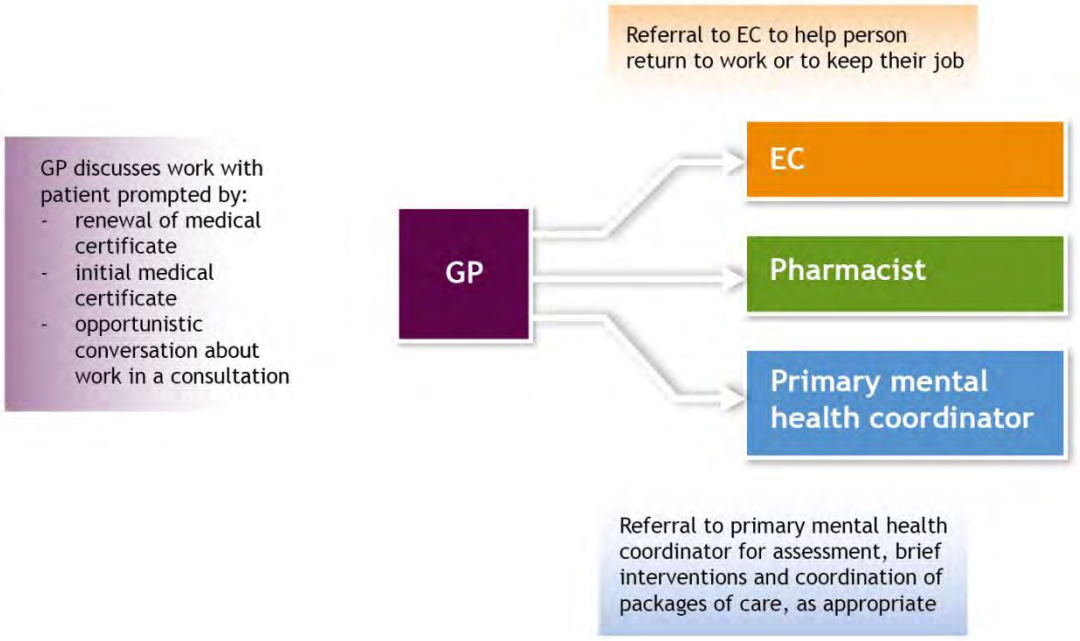


Figure 4: The provision of employment support in primary care

Figure 4 shows that there is no direct referral from the primary mental health coordinator or the pharmacist to the EC, so a referral would need to go back through the GP. Given the evidence on the importance of providing employment support in parallel to mental health treatment, the EC needs to establish good working relationships both with individual GPs, and with the primary mental health coordinator and practice pharmacist.

The evaluation, therefore, gathered evidence to assess the degree of EC integration with GPs across a number of variables, including those identified in the Supported Employment Fidelity Scale. The nature of general practice results in GPs consulting on a one-to-one basis with their patients.. The evaluation, therefore, re-interpreted this integration measure as the presence of two-way dialogue between the GP and EC, and looked for evidence of any form of communication (informal face-to-face conversation, email or phone call) that indicated regular two-way dialogue about a shared client/patient. Evidence was also sought of the extent to which GPs perceived ECs to be part of the practice team, and the extent ECs also perceived themselves in this way.

Figure 4 does not show the role of the Work and Income case managers or the health and disability coordinator. Data on how these relationships worked in practice was not available, as case managers were not interviewed as part of the demonstration because this was not the focus of this evaluation. It is likely that the collaborative aspects of these working relationships, as outlined in the fidelity scale, are still going to be needed for effective implementation of EBSE in primary care settings, although this is clearly an area that needs further exploration.

6.3 Integration in the general practices

Two models of integration – co-located and visiting employment support

Two distinct integration models have been adopted in the demonstration programme: a co-location model where ECs are based within the medical centre (Site A), and a visiting model where ECs regularly call upon medical centres (Sites B and C). Site A has the largest building of the three medical centres. Consequently, it houses more GPs and administrative staff, and is distinguished by having additional space for use by other service providers. Accordingly, Site A was chosen to accommodate the ECs and this was achieved at minimal cost to the practice.

> *…we changed the office upstairs. We added some more phone lines and some IT points and just basically apart from that you wouldn't even know that they're here.* (Representative from Midlands Health Network / NorthCare practice)

Co-located on Site A, the ECs have a desk in a shared office and have access to consulting rooms for meetings with clients. The ECs are co-located on-site from 9am to 1pm daily; the remainder of their time is spent working out in the field, which includes canvassing potential employers in local areas for jobs, meeting with employers and clients, and working at the Workwise office accessing information, organisational resources, and management and supervisory support.

At the other two sites (B and C) the ECs visit at least once a week to collect referral forms. In addition, the ECs have periodic contact with GPs from sites B and C at monthly meetings attended by GPs from all three medical

centres. ECs also spoke about how they contact these GPs as often as they think necessary to discuss referrals or to update GPs on client progress. ECs meet people referred to them from these two other sites off-site from the medical centre. A summary of the models of integration, as well as data on referrals from the sites for the first six months is presented in Table 4.

Table 4: EC integration with the three sites and referral data for the first 6 months (February to August 2011)

Referrals	Site A	Site B	Site C
Total number of referrals made	From six of eight GPs n = 24	From three of three GPs n = 18	From two of two GPs n = 5
Referral rate per GP	3	6	2.5
Acceptance	79% (n=19) of referrals were accepted; 21% (n=5) were declined	72% (n=13) of referrals were accepted; 28% (n=5) were declined	2 referrals were accepted; 3 were declined
Proximity			
Co-location	Present	Not present	Not present
Contact	ECs enjoy daily structured and informal contact with GPs being located within the consulting room area. ECs can also attend daily staff meeting huddles.	ECs usually see at least one GP informally during periodic site visits to pick up referral forms and then at formal monthly practice meetings. ECs go through the consulting room area to pick up referrals.	ECs visit the site periodically to pick up referrals from reception. Physical layout of the medical centre does not provide any opportunities for formal or informal contact with GPs. ECs don't usually see GPs, unless GPs attend monthly cross-site meetings.

This table shows that although Site A had the highest number of referrals made to the programme in the first six months, Site B had the highest referral rate per GP. In contrast, Site C had the lowest referral rate per GP, the lowest number of total referrals made and the lowest acceptance rate. Site C is also associated with the lowest amount of formal and informal contact between the ECs and the GPs, and has a patient population from a higher social-economic group than Sites A or B. These associations are of interest and need further investigation in the second phase of the evaluation.

6.4 Enablers to integration

Experience and networks of ECs

Two Workwise ECs (1.5 FTE) were selected for the demonstration programme, based on their previous experience of working within primary care and experience of the provision of integrated employment programmes in secondary care.

As explained by a Workwise manager, it was a deliberate decision to use experienced ECs.

> *…skilled in working in an attached and collaborative way...to some degree, some of the normal project stuff was easy because we'd looked to do it by using experienced consultants...good connections have been created in a short period of time.* (Representative from Workwise)

In addition, experienced ECs provided ready access to employers based on pre-existing professional relationships. In one case, the EC was also well known to GPs in Site B and understood the work processes of general practice well, an optimal situation that may not always be the case.

The ECs spoke about the value of their prior experience in helping them to pick up on the work flow of the medical centre, and to form connections and working relationships with most of the GPs over a short period of time.

> *In my five-and-a-half years previously, I've worked on virtually all the contracts that we've had...I guess I've had a bit of a grounding all round.* (EC)

> *The feedback that I have from the [GPs] is that the [ECs] are a very good asset to the team and they've enjoyed having them around.* (Representative from Midlands Health Network / NorthCare practice)

This evaluation confirms the importance of EC experience and shows how this supported the integration of the programme. Integration may have taken longer or required additional relationship building activities had the ECs been less experienced and connected.

Reinforcing the relationship between health and work

As may be expected, the evaluation identified different levels of integration between the ECs and individual GPs. General factors that were influential in this included the extent to which ECs had prior networks or relationships with GPs, their frequency of contact with the GP and the extent to which GPs championed the programme. Several factors that appeared particularly influential:

- at site A, the presence of EC co-location
- regular participation in practice meetings
- a higher proportion of enrolled patients on sickness benefits
- physical reminders (ECs' business cards in the GP work stations)

These factors appeared to be stimulating awareness of the availability of the programme as one GP noted:

> *Yeah, even just that [Workwise cards] just remind you that [the employment support programme is] there; even something so simple is powerful you know.* (GPA1)

Physical co-location

In line with the evidence base, this evaluation found that opportunities for interaction between ECs and GPs were increased through physical co-location. This was evident from GPs at Site A who were interviewed.

> *Oh it is brilliant that they're here because…we're difficult to get [hold of] but to just pass [ECs] in the corridor and meet them in the tearoom for 5 minutes is great. …there's no doubt that by [ECs] being here and by having that level of exposure I would imagine our referral rate is much higher than it was prior to their move to the building.* (GPA1)

Given the time constraints within which GPs operate, GPs at Site A indicated that opportunities for informal interactions had facilitated communication and relationship building as well as keeping employment as part of recovery front of mind. By contrast for Sites B and C, opportunities for relationship building were limited to the incidental meetings when ECs visit to collect referral forms and periodic encounters at the combined monthly practices meetings. Reflecting on this, one EC explained:

> *In terms of our flow through the buildings…these are different at different sites. Obviously [Site A], we pretty much go wherever we like…at [Site B] we have to go right to the back of the office, so we actually have to walk through [enabling a chance encounter with GPs]…At [Site C}, we don't. The Workwise referral forms, where we pick them up from, are at the front desk [limiting the prospect of meeting GPs].* (EC)

In contrast to Site A, a GP at Site C explained how they would like to see the ECs more and offered the opportunity for a weekly catch up to have feedback on the people they've referred.

> *I suppose it might be nice to see [ECs] here more often, even if they pop in for a quick visit once a week for 10 minutes or so and they could have a quick catch up about some of the people that we've sent them, that might be useful.* (GPC1)

Participation in the primary care team

It was evident from stakeholder interviews that the ECs are welcomed and invited to attend all staff meetings. This is a key integration mechanism in secondary care and appears similarly important in general practice. The ECs reported being comfortable working in and visiting all three medical centres. As described, the ECs are provided with office space, a desk and use of consulting rooms at Site A. Such provision is likely to be contributing to the extent ECs and GPs feel like they are working as part of the same team at the site. The programme is also integrated and acknowledged within NorthCare's human resource processes and protocols. For example, staff inductions include time with the EC and briefings on EBSE. Reports from some GPs and the practice manager also indicated they were aware of the importance and value of the EC being regarded as part of the primary health care team.

It's really important that if they're here, they feel part of the team [and] the team knows how to utilise them. (Representative from Midlands Health Network / NorthCare practice)
They come to our weekly morning practice meetings. We also see them in the tea room, so there's already a two-way dialogue happening. I've referred two patients to them in the first few weeks. (GPA2)

GPs offered varying views on how best to facilitate engagement with them:

They do turn up to the monthly practice meetings, but those times are not really a good time to have a discussion about the patients that we've sent them. Normally everybody is sitting there listening to a presentation, so it's not really an interactive conversation. (GPA2)

Yeah, we have team meetings here for 15 minutes every day. They are quite welcome to come and pop in to these team meetings and give us a bit of an update. (GPC1)

If someone came to our practice here, we went through the back office and had a cup of tea together. That's how it would work rather than going into a big meeting at quarter to eight in the morning. (GPC2)

GP's feedback indicates that the ECs' participation in the primary care team need to be tailored to local operational preferences, rather than applying a one-size-fits-all approach.

Employment-related conversations

To better understand the activities that occurred prior to a referral, GPs were asked about the nature of employment conversations with their patients. They described raising the issue of employment with patients as part of health treatment conversations related to medical certificate renewals. The ECs' business cards were considered useful prompts for them to discuss employment as part of the patient consultation. GPs reported that they responded to their patient's interest in seeking employment by introducing the programme and EC by name to the patient, and making an instant referral using the electronic referral process (co-designed by Workwise and a GP from Site A).

GPs generally reported that they had several conversations with their patients about employment before being able to send through a referral. Over time these conversations helped the GPs sell the idea of employment as a health benefit and help motivate the patients.

…I don't usually put too much pressure on them. I say 'well, this time think about it, next time come back and tell me', give them information and so on to go home and think about it and read about it. Also give them the opportunity to open the door and let them decide what they want to do. (GPB2)

I say to patients, "you know work has a number of advantages". Firstly it gives them some extra money that they can use. Secondly it gives them some sense of purpose in their day if they've got something to wake up for, as opposed to just sitting on the couch. It does help them get some type of physical activity. It

helps them to build self-confidence so they feel that they're actually productive... In the broader picture it helps the nation as a whole. It sort of takes some off the burden off the tax payer, off the government. I think it's a win/win/win situation, so I'm a big pusher to try to get people into work. (GPB3)

The GPs saw that discussing employment was a part of their role in providing treatment. Several indicated that, in addition to helping motivate their patients, they were also an opportunity to address their patients' fears.

Usually I say their mental health is stabilised now, you should look forward to actually working and working is another step to go back to the bigger world. This getting work is part of the treatment of getting them to a normal life (GPB2)

…some people are comfortable with how things are and they don't really want to have to think about that. It seems too scary to think about work. (GPA1)

A number of the GPs interviewed acknowledged that employment conversations could be difficult with some patients. Despite this challenge, they still believed talking to patients about employment was an important role.

It's difficult because you don't really want to be too harsh on people but we're just trying to help and it's non-threatening …there's no coercion in it. All we're asking them to do is come and have a chat to someone so I don't think it's a lot to ask. (GPA1)

If they just put up barriers straight away then that tells me that you're just hitting your head against a brick wall…although those types of patients are relatively few and far between to be honest. (GPB3)

6.5 Challenges to integration

Communication and systems challenges

Some of the communication challenges identified appear to reflect the general practice setting. Several of these challenges occurred as an outcome of the constraints on GPs' time and the lack of a common patient/client record system between Workwise and the practices. While ECs discussed the value of having some medical information about patients referred to the programme, a consistent or uniform level of information was generally not forthcoming,

It has been quite useful for us when the referral comes through with a few medical notes, saying depression or some doctors put a few little notes and things. It gives us a bit of a heads up before we actually contact the client. That happened for a little bit but now I think most of them just come through just with the client's name and we don't know what the diagnosis is. (EC)

Non-attendance

The ECs reported struggling to make contact with some referred patients or having difficulties completing the assessment phase within appropriate timeframes. Some GPs also discussed the challenge of maintaining patient engagement in the programme post-referral, including subsequent follow-up with an EC.

6.6 Indicators of integration

Communication and feedback

Interview participants indicated that appropriate dialogue was taking place between ECs and GPs, particularly at site A. This included communication about referrals, strategies to motivate a client through the programme, return-to-work plans, and feedback from ECs to GPs about a client's progress. GPs commented on the value of the communication opportunities available.

> *Oh it's brilliant that they're here because a phone call—we're difficult to get in to actually get a phone call but to just pass on in the corridor and meet them in the tearoom for 5 minutes is great.* (GPA1)

> *You know they're here, their feedback is instantaneous; their pickup rate is very fast so we just drop a referral in a box and it gets dealt with quickly.* (GPA1)

ECs also described how they have a preference for being able to talk to GPs directly.

> *If I can I would prefer to speak with them in person because you can just give a bit of context and explain a few things and I can just get the conversation going.* (EC)

The ECs also reported that since achieving employment outcomes takes time, emails about client-related activity is a way of reassuring GPs about the effort they are putting into their shared client to get them into work, and updating them on progress so far.

GPs varied in the communication and feedback they would like from ECs. Some wanted regular updates on progress, while others requested minimal written feedback, but more short face-to-face contact. There appeared some consensus on the value of face-to-face interaction with the ECs, if only for brief informal communication and relationship building.

> *You'll never get two GPs working the same...You have your own style, your own way of doing things...I wouldn't see a [practice] style.* (GPC2)

> *They often give me updates on the patients that I've sent them. Sometimes they pop in here for a quick visit once in a while and have a little chat. It's not too bad in that respect.* (GPB3)

> *Those patients I refer, [the EC] actually updates me [regularly].* (GPB2)

One GP wanted feedback on activities from the EC, because they don't see the patient regularly enough to get that feedback directly.

> *Haven't had any feedback from clients saying,' look I've been to three job interviews in the last month and that's different for me'. I expect that back from the employment consultants in the first instance because you don't see the patients frequently enough to get that.* (GPB3)

This need to create opportunities for secure communication and feedback seemed to be a distinguishing feature of establishing employment support in general practice.

Change in GPs' work practice

Some GPs spoke of how the demonstration programme was affecting their practice through providing the opportunity to integrate employment into their treatment plans.

> *Prior to this pilot we have suggested that people take time off work. Maybe this hasn't been the best thing to advise, but it's the only option we've had. Now that an employment consultant is part of our team we can shoulder tap them and it will be more collegial.* (GPA2)

One GP regarded the presence of ECs and option of referring to the programme as motivating for GPs to themselves advocate the benefits of patients accessing supported employment assistance.

> *Every opportunity I can I talk to them about, "what do you think your chances are of picking up a little part time job to earn a little bit of extra money for yourself and your family?" I say to them, " would you be interested in seeing one of our employment specialists?" If they say yes then I give them a little bit of a spiel about what they do but I send a referral onto them [ECs]. That's usually all I have time for in a visit.* (GPB3)

Summary

This section has identified how the demonstration programme has responded to and addressed the evidence-based principle of 'integration of employment support with healthcare'. The primary role of key stakeholders, notably GPs and EC,s in achieving integration in primary care has been discussed. As in secondary care, integration has been identified as a key component to employment-based services in general practice. Enablers and constrainers to this integration were discussed, particularly the challenges around co-location. The primary indicators of good integration, communication and coordination, and changes to GP's work practice have also been identified and discussed. In order to more fully assess integration and the fidelity of the programme, as applied to primary care, a fidelity quality review was conducted against the relevant aspects of the scale. The results of this review are discussed in the next chapter.

7. Fidelity review

This section highlights the recommendations made through the initial quality review of the demonstration programme, conducted in August 2012 and fed back to the stakeholders in September 2012. The reader is reminded that a full fidelity review was not conducted. Rather questions examining aspects of the programme against items in the EBSE fidelity scale were integrated into the key stakeholder interviews conducted as part of the formative evaluation.

In summary, the fidelity review highlighted that:

- As the programme becomes established, and the EC is out and about more supporting patients at work, it is important to identify health professionals who can also be champions of employment support services, e.g. mental health coordinators, GPs with a mental health liaison role or those with a special interest in the social determinants of health, and practice nurses. This can be supported through the greater presence on-site of the ECs' supervisor from Workwise
- the importance of developing and maintaining a steering group of stakeholders who are action-focused and regularly problem-solve in relation to the practical challenges of sustaining the partnership arrangements
- the integrated employment partnership should be reviewed on a regular basis (six monthly for the first two years) against the Supported Employment Fidelity Scale, to check practice against the evidence-base and provide recommendations for service improvements. This is then used to continually inform the programme action plan.

7.1 Key findings

The review concluded that the employment support programme was now an established part of the general practices. It was positively received by GPs and the other members of the primary care team interviewed. The programme was aligning well with the principles of evidence-based practice. The ECs' presence was clearly having an influence on raising the profile of employment across the practices, particularly where the ECs were physically present.

The review made a number of recommendations that are outlined below. The recommendations are intended to:

- further embed and strengthen the employment programme
- encourage greater collaboration for timely access to the service
- improve the coordination of employment support and clinical treatment for enhanced patient care.

7.2 Recommendations for service improvements

Team approach to supporting patients into competitive employment	**Discussion:** The ECs are considered part of the general practices and have established good working relationships to support the coordination of patient care. It would appear that their presence has brought the relationship between work and health more into the forefront of the healthcare provided. **Recommendation:** Consider routinely recording patient employment status for new patients, as well as collecting data on existing patients, so 'unemployed status' becomes a flag in the patient record. Employment status could be coded in the same way smoking status is coded, i.e. non-smoker, current smoker, ex-smoker. This would also enable the general practice to track changes in the employment status of patients over time. **Recommendation:** ECs to be more proactive in shared team meetings, and could also attend the occasional morning GP huddle. This could include briefing the team on the types of jobs they are looking for (so everyone can, if they wish, keep an eye out for job openings in the local community) and share the results being achieved. These are also important meetings to discuss patients who aren't securing employment and identify if additional clinical input may be required. Find a way to be more proactive in keeping ECs on mailing lists for meetings, and for passing on information to GPs, e.g. of patients whose mental state has deteriorated on the job or who could not make a clinical review for a repeat prescription due to work hours. **Recommendation:** The Workwise team leader should attend the practice group meetings at least once a quarter, as an additional champion for the value of work and to provide information on service developments. The Workwise team leader should also meet with the other integrated health providers, i.e. the mental health coordinator and the pharmacist consultant, to consider how they can further raise the profile of employment within the model of care sites, and to support the transition of patients who are settled into employment, but may still need some input from primary healthcare.
Financial planning	**Recommendation:** ECs to strengthen the relationships with Work and Income. Work and Income case managers could be invited to monthly EC team meetings to discuss shared clients and update ECs on changes to benefits rules and incentives. In addition, ECs could share their knowledge on the basics of in-work calculations and any updates on the benefits rules to the general practices, as relevant and useful, and use their connection with Work and Income to develop stronger working relationships between Work and Income and the general practices.
Employment is integrated with clinical treatment	**Discussion:** People do not have to be symptom-free before returning to work. Therefore, the provision of employment support in parallel to pharmacological and psychological treatments is most effective, both to ensure timely referrals and interventions and to coordinate care. There were several good examples of this coordination of care, particularly between the GP, the primary mental health coordinator and the ECs. As relationships with the ECs strengthen across the practices, this is likely to become more widespread. **Recommendation:** To maximise the time ECs can spend with clients and employers, ECs are assigned to a limited number of referrers, so that high-quality relationships can be easily developed and maintained. The ECs have developed excellent working relationships and communication with a number of GPs across the three sites, but this

	could be improved so that all GPs know the ECs well, and get feedback on referrals (verbal or written), particularly at the Grandview and Thomas Road practices. Our observation was that currently not all relationships with GPs are maximised, which may mean not all the potential referrals are getting through to the programme. The quality of working relationships between GPs and ECs should be monitored when the two further practices come on board, to ensure this isn't diluting the seamless delivery of coordinated care and inhibiting timely access to the programme. **Recommendation:** (As above) ECs could be more proactive in team meetings, with a short slot to share outcomes data, summarise referral data and present case studies (of where things have worked and where they haven't). This will encourage all of the team – the GPs, nurses, pharmacist and mental health coordinator – to think about employment support for patients they have not yet referred. **Recommendation:** Consider inviting ECs to attend the GPs' sickness certification consultations to provide immediate introduction to employment services and reduce the number of 'Did Not Attends' after GP referrals. This may be a more effective referral process in sites where the EC is not physically located. **Recommendation:** Consider ways in which a brief progress and outcomes report (two or three sentences) could be incorporated into the patient's health record. **Recommendation:** Pre-agree with clients an in-work support plan, which can include people other than the EC, e.g. the mental health coordinator, GP, pharmacist, nurse, and explore ways in which this in-work support plan could be simplified and added to patient records.
Supervisory support	**Discussion:** EBSE is deliberately designed as an intensive support service to work with people who have a range of complex employment and health needs. As such, the best programmes make good use of supervisory support, particularly through the ECs' direct line manager. **Recommendation:** That the Workwise supervisor attends the practice group meetings at least once a quarter, and also meets with the practice manager and mental health coordinator on a regular basis. The supervisor can be an additional champion for the value of work, as well as problem-solving any referral and delivery issues, and providing a management link to the employment programme. **Recommendation:** ECs' weekly supervision should focus on their current case lists, and be used to discuss and problem-solve clients who are having difficulty securing work. The team leader can also accompany the ECs in job development, providing what is called field mentoring; this improves outcomes and strengthens working relationships.
Programme leadership	**Recommendation:** That the steering group meetings resume, and are held at least quarterly, and focus on supporting the implementation of the fidelity review recommendations and the findings from the first phase of the evaluation. The steering group, because it has representation across the partners, is an invaluable mechanism for enhancing integration, trouble-shooting issues and addressing systemic barriers, all of which will further improve service delivery and outcomes. Consider whether it would be helpful for the practice manager, mental health coordinator or a GP to be part of the steering group.
Utilising the expertise of the EC	**Recommendation:** At this point of the programme's development, the ECs have a number of people successfully placed in employment and are providing ongoing support (3–6 months). Once people are stable in work, and the ECs are no longer providing

	technical support, but there is still a need for some contact, explore with the team whether another professional could pick up ad-hoc support. This way the ECs would be able to take on more referrals.
Increasing individual patient choice and self-direction	**Discussion:** It was good to see the posters and Workwise business cards clearly displayed in waiting areas and in GP consulting rooms respectively. GPs described how the business cards are a really good prompt for a discussion about work with patients. **Recommendation:** Consider customising the posters to let patients know the practice has an EC and therefore encouraging patients to be proactive and ask their GP about referring them, i.e. "Are you out of work, or concerned about losing your job due to anxiety, depression or other mental health conditions? Talk to your GP about the employment assistance programme at this practice."

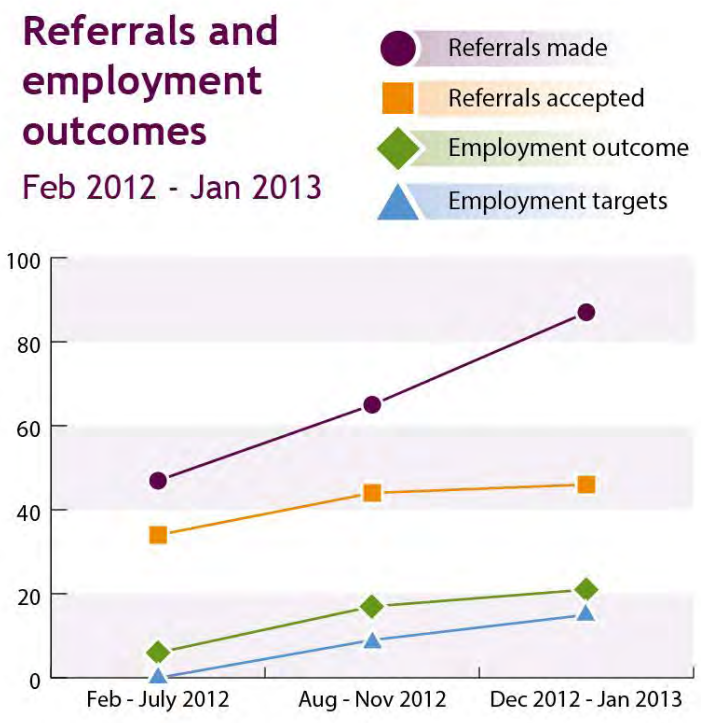
8. Early outcomes

While this evaluation focussed on formative findings related to programme establishment and achieving integration, the demonstration programme has matured enough to analyse some early outcome data. The following chapter highlights the employment outcomes obtained in the first 11 months of the programme. Data analysed includes the total number of employment outcomes and the total number of accepted referrals to January 2013. The stories of two clients who, with assistance through the programme, overcame some significant employment barriers were shared by the ECs and are also presented here.

8.1 Employment outcomes and referrals

Figure 5 below outline the referrals and outcomes to January 2013. In the first six months he GPs from all sites referred 47 patients to the EC services, of which 34 (73 per cent) were accepted. Over the next six months to 31 January 2013, a further 40 referrals had been made, of which 29 (73 per cent) were accepted or pending review, showing a consistent referral pattern across the sites for the second six-month period. At the end of the first six-month period, five employment outcomes had been achieved. By the end of January 2013, the number of employment outcomes achieved as a result of the programme had increased to 20. To compare these outcomes to the delivery of EBSE in secondary care, a cohort of patients would need to be followed over time. This is something the second phase of the evaluation should examine.

Figure 5: Employment outcomes and total referrals to January 2013



8.2 Stories of success

Interviewees were excited by these early employment outcomes and shared some examples of clients' successes.

One older client was very distressed after having recently become unemployed. The EC provided some practical support and interview counselling before a job interview.

> *One client is in his fifties and has only worked in two jobs in his adult life because he's been at those jobs for a long time. So he worked at this place for more than 10 years and then it all ended up in a bit of a disaster, he was in a terrible state…He came here, and maybe 10 days after I met him, he rang me and he said, "You'll never guess what's happened, I've had this job offer". The [potential employer] wanted to interview him, so I got him in and talked to him about what he was going to say when they asked him why he left. One of the questions in his interview was why he left and he told them he had a personality clash with a colleague and it was best that he went. His new job really suits him, he's really happy there.* (EC)

Another client had not yet achieved a paid employment outcome at the time of the interviews, but her symptoms had improved markedly. After working with the EC, she was more motivated, engaging in her community and taking identifiable steps toward employment.

> *One client in her fifties was quite isolated and depressed and hated going on the bus and would stay home. She lives with her daughter and her family. Now she hasn't got a paid job, but she gets up, she goes for a walk every day and she's happy to come here on the bus, whether it's a busy time or not so busy time, it's a bit of a challenge for her. She's got a voluntary job. I teed up the contact and she went and did it all herself. She's got these people coming along to this art group that she does at one of these homes. They want her to do more because she's got so many people coming along. She hasn't got a paid job but I think it's important that people know about that sort of thing because she feels a whole lot better, her life looks a whole lot better and she's got hope that one day she will get a paid job.* (EC)

These early outcomes and personal stories show that the demonstration programme is achieving some results and benefitting referred clients. Phase two of the evaluation should examine the perspectives of the clients in more detail, identifying factors contributing to successful employment outcomes. Continued examination of employment outcomes, and identification of the activities involved in the ongoing implementation of this demonstration, would produce valuable learning for other similar programmes.

9. Discussion

This report has presented key findings from the formative evaluation of the Hamilton primary care employment support demonstration programme. The report considers the feasibility of implementing employment support, based on the principles of evidence-based practice, into general practices and records what effective application of that support looks like. It describes the establishment and early implementation of the demonstration programme, and provides direction for its further development. Phase two of the evaluation should examine the ongoing implementation and working of the programme and examine outcomes in more depth.

9.1 Establishment and initial implementation

The evaluation confirms the timeliness and feasibility of establishing employment support within primary care. Macro-level factors that were supportive of the establishment of the demonstration programme include developments in primary health (including general practices) and secondary mental health care towards more integrated services. Other macro-level factors included current welfare reforms that focus on increasing the employment support provided to people who have health conditions or disabilities, and the growing acceptance that being out of work is a major health risk factor.

Local conditions that supported the establishment of the demonstration programme include strong directive leadership, shared common interest and commitment across key stakeholder groups. Additional supportive factors included effective cross-agency partnerships and a service provider that brought a strong track record, experience and networks to the programme.

At a practice level, supportive factors include a team-based, integrated multidisciplinary approach to patient care, an openness to innovation, GPs with a holistic attitude to health and the social determinants of health. Physical environments that were able to support the co-location of allied health services was also a critical factor. Procedurally, it is important that employment support programmes are introduced to general practices in a way that builds understanding of the core principles of EBSE, particularly service integration and referrals based on patients' interest, not diagnosis, degree of symptoms or any other exclusion criteria. Providing clarity regarding respective roles and responsibilities will help maximise the programme's effectiveness. Reinforcing to GPs the robust evidence base for the effectiveness of EBSE and sharing success stories of people who have successfully secured employment, is likely to enhance their willingness to refer patients to the programme.

This evaluation found that the provision of employment support is now established within the three general practices initially participating in the demonstration programme. Practice staff interviewed held positive views about the programme and saw it responding to a previously unmet need. Advocacy from GPs to expand the eligibility criteria and availability of the programme also reflected their positive response. The programme reinforced the role and importance of employment in a recovery context. An initial quality review of the demonstration against the key principles of supported employment showed that the programme was aligning well to the evidence-base.

9.2 Integration

The integration of ECs within a clinical treatment setting is a distinguishing feature of EBSE. This evaluation identified enablers to this integration in general practices, and demonstrates the achievement of encouraging integration levels within the demonstration thus far.

Identified enablers are important as they describe supportive local conditions for any further roll-out. Enablers include ECs bringing experience in applying the principles of EBSE, that ECs have established professional relationships in primary care, and that GPs are aware of and interested in employment support. Other key enablers included conditions where ECs were able to sustain necessary levels of access, communication and visibility with practice staff, the physical layout or space of practices facilitates this necessary access and engagement, and supportive human resources processes and structures.

The evidence suggested that different levels of integration had been achieved over the three practice sites at the time of the evaluation. Some of these differences are explained by the different models of co-location adopted. Identified indicators of integration included regular and appropriate communication between ECs and GPs, the occurrence of cross-stakeholder communication, ECs attending practice meetings and being valued as team members, and GPs being willing to have ongoing employment-related conversations with their patients and to make referrals.

Sufficient and appropriate integration, and how this is achieved, will not necessarily look the same in primary care settings, such as general practices, as in secondary care. Inevitably, and as in this demonstration, ECs cannot be physically co-located in every general practice. This reinforces the need for mechanisms that facilitate intended outcomes from the integration principle. Whether the co-location and visiting models adopted in this demonstration lead to better outcomes would benefit from further examination in phase two of the evaluation.

> Providing employment support in primary care requires a shift in the role of the GP in the health and welfare interface – from providing sickness certification, to negotiating and helping to facilitate employment support.

GPs were supportive of having ECs on-site, and evidence showed that the co-location model supported the extent to which practice staff considered ECs to be equal members of the practice team. However, there was also some positive evidence of integration within the visiting sites. Comparing site A (co-location) and site B (visiting) showed little difference in the percentage of referrals accepted; a measure that might provide reasonable proxy for referral quality, as well as of the efficacy of the GP and EC interface. Regular site visits by ECs (at least a weekly physical presence), regular attendance by ECs at practice meetings, and mechanisms that facilitated two-way communication were shown to be important in supporting and maintaining the necessary presence and engagement under the visiting model. Recommendations for these activities to increase were therefore made as part of this evaluation. Other strategies such as placing EC business cards in consulting rooms and posters in waiting areas are

important generally for maintaining presence and as visible reminders of the availability of employment support.

9.3 The general practice context

This evaluation begins to examine whether and how employment support works in general practices, and what it looks like. While these questions require further examination in phase two of the evaluation, some early understanding of context emerges from the formative evaluation.

Providing employment support in primary care requires a shift in the role of the GP in the health and welfare interface – from providing sickness certification, to negotiating and helping to facilitate employment support. To undertake this role, GPs will need to believe they are acting in the best interests of their patients by addressing employment issues and, should they recommend employment support, they need to be confident in the resultant process and outcomes. The importance of doing employment support properly (i.e. fidelity aligned) or not at all, in this context, is reinforced.

GPs will need to believe they are acting in the best interests of their patients and, should they recommend employment support, they need to be confident in the resultant process and outcomes. The importance of doing employment support properly (i.e. fidelity aligned), or not at all, in this context, is reinforced.

This evaluation shows that, in seeking to do their best for their patients, GPs may identify a need or see the potential for employment support, regardless of whether the patient in front of them is on a benefit or not. The desire of GPs to make the programme available to all patients with mental health conditions (regardless of benefit status) was accommodated through the Wise Group's funding of the programme which had an open inclusion referral criteria. However, to be sustainable into the future, the programme will require a dedicated funding stream and funding that covers all necessary stages of evidenced-informed supported employment. Funding partnerships between government ministries, Work and Income, primary health organisations and district health boards are likely to be required. Inevitably, both health and welfare objectives will need to be addressed in any funding model, and consideration given to how funding goals may impact GPs' interests and motivations in relation to employment support.

Further to the above, the GP plays a critical role in developing patient interest in employment and their motivation to engage with employment support. While this evaluation provides some initial description of this role, further examination seems important, particularly whether and how any variations in practice may be having an impact within the programme. The desirability of ensuring consistent and evidence-informed practice seems self-evident, and points the way to initiatives and tools that support and guide the GP in their role in relation to health and work.

Patient non-attendance at appointments is a problem in health services, particularly psychiatric outpatient appointments, primary care services (e.g. physiotherapy, counselling, mental health nurse) and general practices. This area has been and continues to be extensively studied (George & Rubin, 2003; Mitchell & Selmes, 2007).

Strategies to address this have included sending out reminder letters and other prompts, providing greater information to the patient on the nature of the appointment, and developing contracts with patients to increase their motivation. Evaluation of these strategies is limited and inconclusive (George & Rubin, 2003).

Initial findings from this evaluation confirm difficulties in ensuring that all patients who were referred to employment support progress to an initial face-to-face meeting with the EC and that follow-up engagement occurs within appropriate timeframes. These issues would warrant further examination in phase two of the evaluation. The importance of ensuring that employment support is timely and rapid is recognised under the principles through the provision of proactive outreach, and was reflected in the recommendations made following the initial quality review of the demonstration (i.e. that outreach could be facilitated and supported through the EC attending GP appointments when medical certificates are being discussed.

This evaluation shows that GPs will have different needs and expectations regarding appropriate communication with ECs, and that, compared to secondary care, consistent communication opportunities and systems will not necessarily exist. The challenge is to tailor communications appropriately within different practice contexts, while being clear about bottom-line communications and information flow requirements. One apparent challenge is how to maintain necessary communications when ECs are not in an intensive co-working relationship with GPs. ECs also indicated the desirability of having a base level of background medical information about patients referred to the programme, but that such consistency was difficult to achieve in the context of GPs' limited time and current record systems. In line with the effectiveness evidence, a recommendation was therefore made to develop shared record-keeping between the ECs and the GPs.

This evaluation identified that the primary mental health coordinator had an important role in the implementation of supported employment in primary care. The primary mental health coordinator helps to facilitate access to the programme, motivates patients to participate, and provides support to GPs in relation to addressing mental health and employment-related issues together. This method of working together is consistent with the research evidence on the effectiveness of providing work-focused health care, where treating physicians and allied health professionals discuss employment with patients as part of a routine clinical consult (Waddell, Burton, & Kendall, 2008). Further investigation of this seemingly complementary and critical role in phase two will help build better understanding of the contribution of the coordinator, and how this helps to align the programme and its operations to the evidence base.

9.4 Early outcomes

This evaluation shows that the demonstration programme is having a range of positive impacts on GPs and within the demonstration practice sites more generally. There is evidence that the programme is acting as a prompt and reinforcement for GPs to have employment conversations with patients, and to consider the integration of employment goals into health care or treatment plans. It provides GPs with an evidence-based alternative when considering their patients' employment situation. The availability and presence of the employment support within GP clinics appears to be raising awareness and reinforcing the importance of employment support as a health intervention within general practice. The number of referrals occurring

between the first and second six months of the project remained consistent and had reached target rates, with employment outcomes increasing as the programme became established.

9.5 Future direction

This evaluation identifies a number of areas for further development or issues for consideration by stakeholders. Some of these may have already been addressed following the initial workshop of the evaluation findings with stakeholders.

The issues identified through this formative evaluation reinforce the general importance of active oversight and management of the demonstration programme. The importance of ongoing engagement and coordination with key stakeholder agencies is also indicated, as they have some influence over the procedural and policy settings within which employment support in primary care is ultimately delivered. The willingness of GPs to refer their patients to employment support will in part be influenced by their confidence that these wider settings will provide fair and equal access to support, and that through seeking employment or assistance to remain in employment, their patients will not be disadvantaged or, in effect, worse off.

The value of reinstating regular meetings of the steering group, regular fidelity reviews, and developing the role and input of the ECs' supervisor[6], are all identified through this evaluation. Ideally the steering group will provide a sustainable mechanism through which stakeholders can regularly problem-solve and act to guide the delivery of evidence-based employment support. Regular review of the programme against the Supported Employment Fidelity Scale should be used to check practice and process against the evidence base and guide service improvement. As the demonstration progresses, the ECs are likely to become increasingly involved in supporting patients who they have assisted into employment, and less able to advocate for and maintain the visibility of the programme within the practices. Achieving this may require a greater on-site presence from the ECs' supervisor and this supervisor having a more active role in liaising with key stakeholders.

> Any further expansion of the programme and subsequent resourcing needs to maintain a firm focus on the integration principle, as core to achieving effective employment support.

The evaluation also identifies the need to further embed employment support within the primary care context, particularly through increasing the frequency of the ECs' interactions with GPs and through tailoring the nature of these interactions to align with primary care workflows. As discussed, there would be value in further considering and developing the role of the GP as programme advocate, and in developing patient interest in employment and motivation to engage with employment support. This evaluation reinforces the importance of seamless and timely referral processes, procedures that ensure that ECs are able to routinely access necessary background information about patients, and that, once a patient has been referred, ECs are able to initially engage with them within appropriate timeframes.

[6] Potentially, the equivalent of the 'employment programme team leader' as described in the fidelity scale

The regular physical presence of ECs within the clinic setting is important. However, further evaluation is needed to determine what constitutes a sufficient presence and what this means for optimally locating ECs. In the meantime, any further expansion of the programme and subsequent resourcing needs to maintain a firm focus on the integration principle, as core to achieving effective employment support. The supportive and enabling local conditions for programme establishment, summarised earlier, also provide guidance to any future expansion effort.

The evaluation also highlights the need for further clarity around what Work and Income's role should be in the provision of employment support in primary care. This area may warrant further examination in phase two of the evaluation.

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Appendices

Appendix A: How evidence-based supported employment principles could be operationalised in primary care
Appendix B: Outcome chain for demonstration programme
Appendix C: Realist evaluation models
Appendix D: Key stakeholder interview topic guides
Appendix E: Recordbase data and potential use in evaluation

Appendix A: How evidence-based supported employment principles could be operationalised in primary care

EBSE is deliberately designed as an intensive support service tailored to individual need. As such, employment assistance requires a mobile and flexible approach to engage with job seekers and employers to maximise opportunities that become available in the community. ECs spend a large part of their time out in the community establishing employer connections, and searching for and developing employment opportunities for people specific to their requested needs. Once people are in work, the focus is on supporting them, as well as supporting their employers if necessary. How the eight principles of EBSE could be operationalised in primary care is described below.

Everyone is eligible

Primary health care professionals can refer any patient with a mental health condition who expresses an interest in giving employment a try. Research shows that people do not have to be symptom-free before returning to work and that wanting a job is overwhelmingly the most important individual factor influencing successful placement in paid employment (Grove & Membrey, 2005). Age, gender, diagnosis, level of symptoms, ethnicity and co-occurring substance dependence are not factors that predict return to work (Campbell, Bond, & Drake, 2011). The best predictor at an individual level is the person's degree of self-efficacy (Grove & Membrey, 2005). It is, therefore, very important that people are not screened out of accessing employment services, due to perceived notions of job readiness based on their individual characteristics.

Competitive employment is the primary goal

The fundamental outcome of any employment programme operating to the evidence-base is that paid employment (part-time or full-time) is the goal for everyone who wants a job, and is the primary focus for the employment programme. Work trials, voluntary work or pre-vocational training should be time-limited and clearly linked to the individual's employment goals, and support to access these opportunities can be provided by other professionals and agencies, rather than using up the limited capacity of an employment support specialist.

Employment consultants are integrated with clinical treatment services

One of the most crucial aspects of the approach is the quality of joint working (i.e. employment support is provided in parallel to clinical treatment, rather than afterwards) between ECs and mental health treatment professionals, with the most effective method being co-location, irrespective of who employs them (Shepherd, Lockett, Bacon, & Grove, 2012). By actively taking part in treatment reviews, influencing referrals and sharing in decisions in this way, ECs are a resource for the clinical team and patients, as central and equal members of the team not peripheral add-ons. In addition, it means that health professionals can offer immediate clinical support to patients before or after they gain employment.

The challenge of operationalising this principle in primary care is to identify the equivalent to the secondary care multidisciplinary team, to ensure integrated working. In primary care, this is the GP. Hence, GPs should be the main focus of the relationship building and communication carried out by the EC.

Job search is rapid and consistent with individual preferences

Working closely with someone's personal interests and experiences is in line with a recovery philosophy and significantly increases the chances of the person enjoying and hence retaining a job. An employment plan, developed with the client and shared with the clinical team, is among the first activities carried out by the EC. The plan underpins the job search process and any further assistance provided by the EC and the clinical team. Rapid engagement in job seeking, aligned with the local labour market, also helps to maintain an individual's initial interest in and motivation to work. This same practice can be conducted in primary care.

Support is time-unlimited and individualised to employee and employer

The place-then-train approach of EBSE makes getting a job the start of the process, rather than the end point. Individualised support around the pros and cons of disclosure of a mental health condition and the effective management of other similar personal information are important discussions that are held between the EC and the individual at all stages of the job search and acquisition process. The EC then tailors in-work support according to the needs of the individual and, where appropriate, the employer, for as long as it is needed. Once again, this principle is likely to be no different in primary care and can be applied effectively.

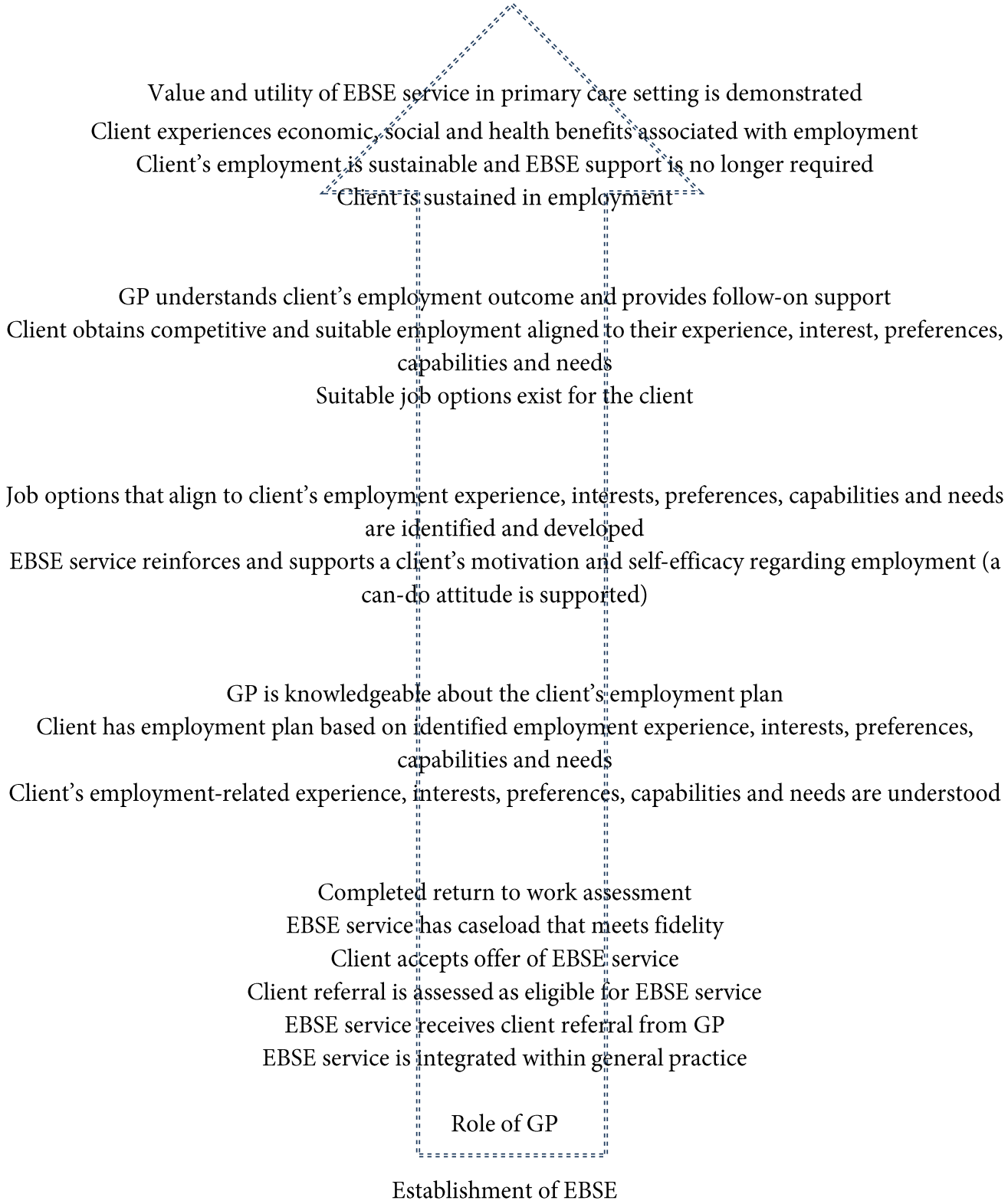
The provision of welfare benefits counselling, to support the person through the transition from benefits to work

The process of managing the transition from welfare benefits to work for the individual, and providing advice on in-work benefits, is a necessary recognised step in achieving sustainable employment outcomes. In this way, offering assistance in obtaining individualised benefits counselling is predicated on their being good relationships between the EC or healthcare practitioner and the welfare benefit agencies. Once again, this principle is applicable to primary care.

Job development

Employment specialists actively seek out job openings and opportunities in the local labour market, in line with the skills and preferences of their current caseload of job seekers. They spend a large amount of time getting to know local employers, understanding their recruitment needs and working with the employer to find a suitable job match. As well as the usual vacancies, employment specialists working to best practice make use of what has been referred to as 'the hidden labour market', i.e. job openings that employers might not advertise, but do have a need for staff for; these are often part-time. Job development is essential to secure jobs in times of economic downturn. This principle will be as applicable to ECs working in primary care, as it is in secondary care.

Appendix B: Outcome chain for demonstration programme



Appendix C: Realist evaluation models

Two realistic evaluation models are provided below. Each model derives from an outcome specified in the outcome chain presented in Appendix B. Both models are hypothetical at this stage and should be considered working drafts only.

Example A

In example A, the outcome from the outcome chain is "EBSE service reinforces and supports a client's motivation and self-efficacy regarding employment (a can-do attitude is supported)". The context is the patient profile.

Context	Mechanism	Outcome
Client believes employment is beneficial for their mental health. Their interest in working follows free choice. They believe they can work and that they are employable. Their self-assessment is supported by a recent work history and previous stable employment. They understand a return to work is financially advantageous.	Reinforcement of existing interest and self-efficacy	Client engages in all stages of EBSE and their likelihood of obtaining appropriate competitive employment is enhanced
Client believes employment is beneficial for their mental health. Their interest in working and belief that they can work and in their employability is stimulated by the offer of EBSE. Their self-assessment is supported by a recent work history and previous stable employment. They understand a return to work is financially advantageous.	Development and maintenance of interest and self-efficacy	Client engages in all stages of EBSE and their likelihood of obtaining appropriate competitive employment is enhanced
Client is ambivalent about whether employment is beneficial for their mental health, whether they can work, and whether they are employable. They have been out of work for some time and have a history of unstable employment. Given their limited capacity for work beyond part-time employment, a return to work is unlikely to be financially advantageous.	Interest and self-efficacy is not reinforced or developed	Client disengages from the EBSE service and their likelihood of obtaining appropriate competitive employment is not enhanced

Example B

In example B, the outcome from the outcome chain is "Client obtains competitive and suitable employment aligned to their experience, interest, preferences, capabilities and needs". The context is the employment market.

Context	Mechanism	Outcome
Job market is such that there are sufficient employment opportunities appropriately aligned to client's employment interest, history, experience, skills and support needs. Available job opportunities are such that employment would have beneficial outcomes for client (economic, health and social).	EBSE links the client's employment experience, interest, preferences, and support needs, with appropriate competitive job opportunities (within desired timeframes)	Client obtains competitive job aligned to employment experience, interest, preferences, and capabilities (within desired timeframes) Client experiences associated economic, health and social benefits
Job market is such that there are limited employment opportunities appropriately aligned to client's employment interest, history, experience, skills and support needs Available job opportunities are such that employment would have beneficial outcomes for client (economic, health, social)	EBSE links the client's employment experience, interest, preferences and support needs, with appropriate competitive job opportunities (however, outside desired timeframes)	Client obtains competitive job aligned to employment experience, interest, preferences and capabilities (however, outside desired timeframes) Client experiences associated economic, health and social benefits Or Client disengages from EBSE, and loses motivation and interest, as job search and placement is not rapid Client does not experience the economic, health and social benefits associated with employment
Job market is such that there are no employment opportunities appropriately aligned to client's employment interest, history, experience, skills and support needs	EBSE cannot link the client's employment experience,	Client's benefit or employment status remains the same Or

	interest, preferences and support needs with appropriate competitive job opportunities	Client obtains competitive job, but it is not well-aligned to their employment experience, interest, preferences and capabilities And therefore, Client's employment may not be sustained Client does not necessarily experience the economic, health and social benefits associated with employment

Appendix D: Key stakeholder interview topic guides

- Employment consultant interview schedule
- GP interview schedule
- Practice manager interview schedule
- Midlands Health Networks mental health manager interview schedule
- Workwise management interview schedule

Employment Consultant Interview Schedule

Interviewer: ---------- **Date & Time: ---------**

Interviewee: ----------

Introduction and consent process

- **Paraphrase purpose of the evaluation and interview; confirm timing (15 mins)**
- **Cover confidentiality and consent**
- **Address any questions**
- **Sign consent form**

Part One: Focus on the pilot demonstration in relation to its setting in the GP Practices

Background

1. **Could you background the process through which you became involved in the demonstration project?**

PROBE

a. Previous experience in EBSE

b. Motivations/interests in EBSE in primary care

2. **Given your experience of EBSE in secondary care, did you have any initial views on the feasibility of EBSE in primary care?**

PROBE

a. Differences between primary and secondary care setting

Establishment and integration process

3. **What role, if any, did you have in the establishment of the employment program within the practices?**

PROBE

a. Ideally, should you have had more or less involvement? Why?

4. **What specifically was done to establish and integrate the employment program within each practice?**

PROBE

a. Any specific communication of EBSE principles, GP role, appropriate referrals etc to staff

b. Whether/how the 'close proximity' criteria was addressed

c. Strengths/weaknesses of the establishment/integration process

d. Impacts of establishment process on how the program is currently operating

5. **To your knowledge, were practice staffs' existing attitudes/beliefs about the role of employment in MH recovery examined or addressed during the establishment phase?**

PROBE

a. Current attitudes/beliefs across the practices/across GPS?

b. Is this impacting in any way?

Integration

6. **What current processes integrate your role and work as ECs into the practices (examine differences across sites)**

PROBE

a. Regular contact/meetings between GPs and ECs

b. Integration of relevant employment documentation into patient notes

c. EC ability to discuss individual clients/employment goals with GP

d. Shared decision-making between EC and GP

e. Other support provided to program and its goals by the practices (e.g. displays employment material, communicates employment outcomes)

7. **To what extent is this current level of integration acting in support of your work and program goals? What else needs to happen?**

Referral process

8. **Could you describe how the referral process is currently operating?**

PROBE

a. Operational differences across sites

b. Volume/quality of referrals – reasons?

c. 'Appropriateness' of referrals regarding non-exclusion

9. Post-referral, what further involvement, if any, do GPs and other practice staff have with the program and the patients referred?

PROBE

a. Barriers to further involvement

Impacts/ outcomes

10. Do you believe the employment program has impacted the practice of GPs or other members of practice staff in any way?

PROBE

a. Clinical practice (referrals, medical certificate process)

b. GP/practice attitudes to value/place of employment in recovery

c. Conservations/thinking about role of employment for patients who haven't yet been referred

11. What impact is this having on the outcomes you would expect to see through EBSE?

(If little or no impact/change observed for GP/practice)

PROBE

a. Why is this? What needs to change or be developed within the program?

Part Two: EBSE implementation post-referral process and initial outcomes/impacts

Prep and planning/Active job Search/Job placement and follow-on supports

12. Could we start by re-capping how the program has been set up and resourced across the three practices

PROBE

a. Serving the embedded site and non-embedded site

b. EC allocation to the different practices

c. Workload management

13. A key goal of the evaluation is to understand the extent to which factors in the primary care context are acting to support or constrain the delivery of EBSE. Could we use this part of the interview to reflect on the three key stages of EBSE – preparation and planning; job search; and job placement/support and discuss how you have been developing these parts of the service in response to the primary care context?

PROBE

Probes throughout this section will examine what is different about the primary care setting; what factors/context is enabling or constraining EBSE; how practice or process is being adapted or developed in response; feasibility of fidelity given context and practice

Probes will be used to understand the impact or influence from the level of practice integration described in the first part of the interview

14. Can we start with the processes you have established once a referral to the program is received…

…Initial client engagement

PROBE

a. What has been required to initially engage clients; inputs, process, timeframes required

b. Levels of client interest/readiness - impacts on inputs, process, timeframes required

…Movement to initial vocational assessment

PROBE

a. Inputs, process, timeframes required to complete initial assessment (e.g. no. of required sessions)

b. Reasons for declined at this stage (pre or post the initial assessment)

…Movement to job search phase

PROBE

a. Inputs, process, timeframes required to move into job search phase

b. Job search fidelity

- rapid job search
- work incentives planning
- evaluating disclosure
- individualized job search

- job development -frequency and quality of employer contacts
- on-going vocational assessment
- diversity of job opportunities

c. Barriers/enablers to job search fidelity

…Employment follow-on supports ***(acknowledge that last time we spoke this part of the service was still being developed)***

PROBE

a. Individualized and time-unlimited follow-along supports

b. Provision of career development

c. Provision of employer support

d. Transition to step-down job supports

15. Who else, if anyone, is supporting you in the delivery of the EBSE service? What support/input? How and when is this being provided?

PROBE

a. Role/input of employment supervisor

b. Availability of caseload cover

c. Extent receiving executive team member support

d. Extent GP practices are providing broad employment supports and encouragement

16. Are other stakeholders/services being engaged in or involved in the program? Who? When? How? Why not?

PROBE

a. Referrals to other services?

b. Liaison with WINZ staff?

c. Other MH service supports

<u>Impacts/outcomes</u>

17. In your view, what have been the key impacts or outcomes from the program so far?

PROBE

a. Quality of employment opportunities/outcomes

b. Other impacts or changes for clients

c. Changes in GP/practice attitudes or practice.

18. Are there specific barriers to employment outcomes in the primary care context that are different to secondary care? How are you responding to these?

PROBE

a. Notion of 'employability'

b. Extent the job market can be 'developed'

19. On reflection, what have been the key factors that have supported the establishment and integration of the program so far within the practice?

PROBE

20. What have been the key challenges/constraints?

PROBE

a. Impact on key aspects of fidelity

b. ECs ability to provide employment services only

c. ECs ability to conducts all phases of employment service

21. What if any needs exists for change or further development within the program?

Close - thank you

Recap on what happens now – re data, access to interview summary, workshop process, evaluation report

GP Interview Schedule

Interviewer: ---------- **Date & Time: ---------**

Interviewee: ----------

Introduction and consent process

- **Paraphrase purpose of the evaluation and interview; confirm timing (15 mins)**
- **Cover confidentiality and consent**
- **Address any questions**
- **Sign consent form**

Ask GP to briefly introduce themselves (how long a GP, position (full/part time) and time in practice)

1. Could you please describe your role and involvement in the employment program to date

PROBE

a. How developed understanding of program and role (e.g. briefings)

b. Understanding of role

c. Satisfaction that introduction process provided sufficient understanding of program and role, including referral process

2. In the past, how have you approached the issue of employment within the treatment of your patients who have mental health conditions?

PROBE

a. Extent employment is recognized as issue facing MH patients (e.g. what % of MH patients are known to be unemployed)

b. Reasons for past approach (e.g. beliefs about employability, what patients 'need' to return to employment)

3. Have you made any referrals to the program so far?

PROBE

(if yes)

a. How many? Why these patients? How was patient 'interest' determined?

b. What was the consultation context (e.g. medical certification process). How was employment raised in this context?

c. Is there anyone who you definitely wouldn't refer?

(if no)

d. Why not? What has prevented referrals so far?

(all)

e. General issues/challenges in determining eligibility and appropriate referrals

4. (*If made referrals*) Following the referrals made you have made, what further involvement, if any, have you had with the employment program and with the patients you referred?

PROBE

(if *involvement*)

a. Why this involvement? What has supported/enabled this?

b. What have been the benefits of this?

c. Would you like more/less involvement?

(if *no involvement*)

d. Why not? What has prevented any further involvement?

5. Have you observed any impacts or changes occurring for patients as a result of the employment program?

PROBE

(if *yes)*

a. Awareness of employment outcomes

b. How other impacts/changes have been evidenced

c. Have observed impacts/changes influenced views/practices regarding employment in recovery

(if no)

d. Why is this? What needs to change or be developed within the program?

6. Do you believe the employment program has impacted your practice in any way?

PROBE

(i*f yes)*

a. Evidence of impacts in relation to:

- having employment conversations/raising interest in employment
- medical certification practice
- integration of employment plan into recovery plan

(if no)

b. Why is this? What needs to change or be developed within the program?

7. Are there any other ways you believe the employment program should be developed or changed to best fit the primary care context?

<u>Close - Thank you</u>

a. Further input into evaluation

b. Return of summary key findings

Practice Manager Interview Schedule

Interviewer: ---------- **Date & Time:** ---------

Interviewee: ----------

Introduction and consent process

- **Paraphrase purpose of the evaluation and interview**
- **Cover confidentiality and consent**
- **Address any questions**
- **Sign consent form**

1. **Could you please describe your role as practice manager across the three sites in the practice (Pukete, Grandview, Thomas Rd) and provide a little background to each practice**

PROBE

Any differences in patient profiles; patient to GP ratios
Any other 'contextual' differences between the practices

2. **To your knowledge, why did the practice get involved in the pilot?**

PROBE

Was existing interest/commitment to role of employment in MH recovery a reason?
Why Pukete Rd was chosen as the embedded site

3. **In your view, what differentiates the employment program from other programs of vocational rehabilitation/support?**

PROBE

How understanding developed (e.g. briefings)

(*given above*) Could you describe to me what a successful program would like look?

PROBE

Why is that [factor/characteristic] important to success?

(*given above*) Did you, or do you, have any initial views on the feasibility of such a program in primary care?

PROBE

Why is that [factor/characteristic] an enabler/barrier in primary care?

4. **Could you please describe your role and involvement to date in the establishment and implementation of the employment program**

PROBE

What was involved in establishing the program?
Who else was involved?
What changes were required within the practice?
What did this mean for the practice/ for staff?

5. **What specifically was done to establish and integrate the role of the employment consultants within each practice?**

PROBE

Extent 'close proximity' criteria has been able to be achieved

6. **Could you describe to me how the employment program currently operates within the practices?**

PROBE

Operational differences across sites

6a. Referral process

PROBE

Volume of referrals – reason?
'Quality' of referrals – how is 'quality' defined– why current quality?

6b. Post- referral, what further involvement, if any, do the GPs have with the program and the patients referred?

PROBE

EC attachment/integration within treatment team
Regular (weekly) meetings between GPs and ECs
Integration of relevant employment documentation into patient notes
EC ability to discuss individual clients/employment goals with GP/shared decision-making

6c. What, if any, further involvement do you or other staff have in the program?

PROBE

Provision of Executive Team member support

6d. What else, if anything, are the practices doing to support or encourage the employment program and its goals?

PROBE

e.g. displays employment material; communicates employment outcomes

7. **Have you observed any impacts or changes occurring for patients as a result of the employment program?**

PROBE

Awareness of employment outcomes
How other impacts/changes have been evidenced

(If little or no impact/change observed for patients)
Why is this? What needs to change or be developed within the program?

7a. Do you believe the employment program has impacted the practice of GPs or other members of staff in any way?

PROBE

Clinical practice (referrals, medical certificate process)
Attitudes regarding value/place of employment in recovery
Conservations/thinking about role of employment for patients who haven't yet been referred

(If little or no impact/change observed for GP/practice)
Why is this? What needs to change or be developed within the program?

8. **On reflection, what have been the key factors that have *supported* the establishment and integration of the program so far? What have been the key *challenges/constraints*?**

PROBE

Patients /community profile
Patient numbers / workload and manageability
GP's work preferences (hrs, specialization)
Operational process/systems

8b. What, if any, other change or further development is required within the program?

9. **Do you have any final comments that you would like to share with me or that would be helpful for the evaluation to consider?**

<u>Close - Thank you</u>

Midlands Health Networks Mental Health Manager Interview Schedule

Interviewer: ---------- **Date & Time:** ---------

Interviewee: ----------

Introduction and consent process

- **Paraphrase purpose of the evaluation and interview**
- **Cover confidentiality and consent**
- **Address any questions**
- **Sign consent form**

1. **Could you please briefly introduce your role within Midlands Health Networks**

2. **Could you please describe your and any other Midlands Health staff involvement in the establishment of the demonstration project so far**

PROBE

a) Why and how Midlands Health got involved

3. **(depending on above) What was required to establish the project in primary care?**

PROBE

a) Differences in requirement between primary and secondary care context
b) Whether differences were anticipated to impact the project and whether anything was undertaken during establishment to address these

4. **In your view, what differentiates the demonstration project from other programs of vocational support?**

5. **Did you have any initial views about the feasibility of such a program in primary care and has this view changed (in what way)?**

PROBE

a) Why is that [factor/characteristic] likely to support /be a barrier to the program
b) What success looks like – early signs you have been looking for
c) Do anything differently if you were starting again in these sites?

6. **To your knowledge, what specifically was done to integrate the program within each practice?**

PROBE

a) Issues/challenges in process due to primary care context
b) Any processes specifically undertaken so that GPs/practice staff understood EBSE principles, GP role, appropriate referrals etc

c) Specific changes required within the practices to integrate the program
d) Extent the embedded model is able to satisfy the 'close proximity' criteria

7. Why was Pukete Rd was chosen as the embedded site

8. What further role or input are you or other Midland Health staff now having in the on-going implementation of the program?

PROBE

a) Extent that Executive Team fidelity support is being undertaken
b) Extent the role is understood in fidelity terms [proxy or supplement to clinical director/ implications re mental health team?]
c) Perceived effectiveness of the role [in respect of other roles/functions and tasks]

9. Are other stakeholders/services involved in the program? Who? When? How? Why not?

PROBE

a) MH referrals to other services
b) Liaison with WINZ staff
c) Other MH service supports
d) Should others by involved? Why?

10. In your view, what have been the key impacts or outcomes from the program so far?

11. Are there specific barriers to employment outcomes in the primary care context that are different to secondary care?

PROBE

a) How should these be addressed?

12. On reflection, what have been the key factors that have consolidated the establishment and integration of the program so far within the practice?

PROBE

a) Extent these same/different to secondary care

13. What have been the key challenges/constraints more recently?

PROBE

a) Extent these same/different to secondary care
b) How should these be addressed?

14. What, if anything, should change or what further development is now required within the program?

PROBE

a) Why? How would this support the program and program goals
b) What would need to be understood further and/or specifically planned for to effectively extend the demonstration to further sites.

Close- Thank you

Workwise Management Interview Schedule

Interviewer: ---------- **Date & Time:** ---------

Interviewee: ----------

Introduction and consent process

- **Paraphrase purpose of the evaluation and interview**
- **Cover confidentiality and consent**
- **Address any questions**
- **Sign consent form**

1. **Could you please briefly introduce your role and position within Workwise**

2. **Could you please describe your involvement to date in the demonstration project**

PROBE

a) Motivations/interests in EBSE in primary care

3. **Could you background the process through which Workwise became involved in the demonstration project?**

PROBE

a) Perceived differences between primary and secondary care setting

b) Extent differences were anticipated to impact EBSE in primary care and what successful EBSE in this context would require and look like

4. **What were your initial views on the feasibility of EBSE in primary care?**

PROBE

a) Anything specifically undertaken during the establishment phase to address/respond to anticipated difference

5. **What specifically was required to establish and integrate the program in each practice?**

PROBE

a) Issues/challenges in process due to primary care context

b) What specific process for ensuring GPs/practice staff understood EBSE principles, GP role, appropriate referrals etc

6. **To what extent has the 'close proximity' criteria been able to be satisfied through the establishment process?**

PROBE

a) How/to what extent is the embedded model able to satisfy the 'close proximity' criteria [fidelity concept / item …]

7. Why was NorthCare Pukete Rd chosen as the embedded site?

8. What other stakeholders needed to be engaged in the establishment and integration process?

PROBE

a) Role/purpose of these partnerships in supporting the program

b) Were these existing WW partnerships

c) How well are these partnerships now operating in regard to role/purpose

9. On reflection, overall strengths/weaknesses of the establishment/integration process

PROBE

a) Impact on program

b) Do anything differently if you were starting in these sites again?

10. What supports are now being provided by Workwise management to the ECs as part of the routine implementation of the program?

PROBE

a) Role of employment supervisor [fidelity concept / items …]

b) Availability of caseload cover [fidelity concept / items …]

c) Receipt of executive team member support [fidelity concept / item …]

d) Extent GP practices are providing broad employment supports and encouragement [fidelity concept / item …]

11. Are other stakeholders/services involved in the program? Who? When? How? Why not?

PROBE

a) Referrals from /to other services?

b) Liaison with WINZ staff?

c) Other MH service supports

12. **In your view, what have been the key impacts or outcomes from the program so far?**

13. **Are there specific barriers to employment outcomes in the primary care context that are different to secondary care? How are you responding to these?**

14. **On reflection, what have been the key factors that have consolidated the establishment and integration of the program so far within the practice?**

PROBE

a) Impact on progress towards fidelity

b) Impact on feasibility of a high-fidelity supported employment initiative in primary care

15. **What have been the key challenges/constraints most recently?**

16. **What, if any, change or further development is now required within the program?**

PROBE

a) Why? How would this support the program and program goals in current settings

b) What would need to be understood further and/or specifically planned for to effectively extend the demonstration to further sites.

Close - Thank you

Appendix E: Recordbase data and potential use in evaluation

The following table shows areas of programme performance that are measurable through routinely collected data (Recordbase), and how the data could be used in the future process and outcome evaluation of the demonstration programme.

Aspect of programme	Measures	Potential use in evaluation
Client referral and engagement data	Total number of clients referred to EBSE (by practice and time period) Total number of 'active' , 'pending' and 'declined' clients (by practice and time period) Summary of reasons for decline Total number of new 'active' clients (by practice and time period) Total number of 'active' clients at the start of the Prep & Planning (PP) and Job Search (JS) phases (by practice and time period) Total number of 'active' clients discharged during Prep & Planning and Job Search phases (by practice and time period) Summary of reasons for discharge Total number of 'active' clients with an employment outcome (by practice and time period) Total number of employment placements (by time period) Total number of clients discharged during the Placement Support (PS) phase (by practice and time period)	Attrition rates Time that clients spend in respective states (pending, active) and phases
Programme referrals active or declined client	Birth date Ethnicity Gender Education status Primary mental health diagnosis and complexity (co-morbidities (Y/N) and acute diagnosis (Y/N)) Employment status at referral	Description of service users and service use Time out of work by

	Time out of work at referral (<2 months, 2–6 months, 7–12 months, 12+ months)	length of time to job placement and employment outcomes
EBSE service	Time to entering job search phase (average time in days) Time to job placement (average time in days) Caseloads (total number of 'active' clients per EC, and total number of clients in PP, JS and PS per EC per month) Proportion of 'stay at work' clients in caseload	Description of caseload mix by clients in respective phases Description of rapid job search and time to placement
Employment outcomes	Total number of 'active' clients with an employment outcome (by practice, time period and demographics) Total number of employment placements (by time period) Average job tenure of successfully placed clients Total number of clients in PS and average duration	

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