Process evaluation of employment support in Wellington general practices

An initiative between Workwise, the Ministry of Social Development, Work and Income, Compass Health and Newtown and Waitangirua general practices

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 (IPS)	Individual Placement and Support (IPS) is an evidence-based practice developed to help promote the recovery of people who have serious mental illness through work. This approach is defined by eight practice principles, underpinned by its own evidence base and a 25-item fidelity scale (Drake, Bond, & Becker, 2012). It is characterised by individualised, intensive, rapid job search and on-going support with the assistance of an employment consultant. Given the strength of the evidence, Individual Placement and Support is also known as Evidence-Based Supported Employment or EBSE. EBSE is the term used throughout this document.
Employment	Employment in competitive jobs (either part- or full-time) paid at the minimum wage or above, in contrast to non-competitive jobs such as volunteer jobs, unpaid internships, sheltered work or set-aside jobs for people with disabilities (Drake et al., 2012).
Employment consultant, 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 uses the term employment consultant, so this term has been adopted in this report.
Invalid's, Sickness and Unemployment Benefits	Work and Income New Zealand offers financial support in the form of these benefits qualifying individuals not in work. The type of benefit depends on the individual's circumstances and the reason they are not in work. From July 2013 previously separate benefit categories and benefit titles were changed. Invalid's Benefit has become the Supported Living Payment and both Sickness and Unemployment Benefits are now referred to as Job Seeker Support[1]. As the data collection was completed before the changes occurred, the previous terms are used by interviewees and throughout the report.
Mental health issues	Mental health issues, also referred to as mental disorders or illness, can impact on an individual's life in areas such as self-care, employment and personal relationships. Common mental health diagnoses include mood disorders such as depression or bipolar disorder, anxiety disorders such as phobias or post-traumatic stress disorders and psychotic disorders such as schizophrenia (Drake et al., 2012). The degree of impact that a mental health issue has on a person's life varies and can be mild to severe.

[1] http://www.workandincome.govt.nz/individuals/benefit-changes/new-benefit-categories.html

Part-time work	Part-time work is considered to be any number of hours a week less than full-time. Full-time work is usually around 35-40 hours a week (Ministry of Business and Innovation, 2010).
Patient, client	Individuals who are supported by the employment support demonstration are referred to as patients by general practitioners (GPs) and other health professionals, but employment service Workwise refers to them as clients. These terms are interchangeable in this evaluation report.
Welfare reform	The Ministry of Social Development has announced a programme of work to implement recommendations outlined in the Welfare Working Group's report (Rebstock et al., 2011), which came into effect from July 2013. Work and Income are implementing a number of these changes that impact on people with health conditions and disabilities. The focus is on providing greater access to employment support services and taking an investment approach to reduce long-term benefit dependency. The term welfare reform is used in this report to refer to these current changes.

Key findings

This evaluation found that through coordination and communication, GPs, Workwise and Work and Income began to address the system barriers experienced by clients with mental health issues wishing to pursue competitive employment.

Clients' profile

- Thirty-four clients enrolled in Workwise services through the demonstration programme at their general practitioner. The clients are representative of the two Wellington practices' overall populations and had experienced mental health issues, and diagnoses included depression, anxiety, bipolar disorder and schizophrenia.
- Two-thirds of 24 clients with recorded information had been unemployed for two years or less; one-third had been unemployed more than two years.
- Many clients were receiving Work and Income benefits at the time of enrolment with the programme. Of the eighteen clients whose benefit status was recorded, the majority were receiving a Sickness Benefit, with a small number receiving an Invalid's or Unemployment Benefits. A number of clients were not receiving benefits but were "benefit appropriate", accessing Work and Income services for the first time after their Workwise enrolment.
- A key inclusion criteria for the Ministry of Social Development's cohort trial[2] that ran in conjunction with the demonstration programme was clients' long-term benefit (≥52 weeks continuous) status. A review of client demographic and interview data suggests that most clients met the age and willingness to work criteria, but only a small number were eligible due to failure to meet the long-term benefit criteria.
- Prior to enrolling in the demonstration programme, interviewed clients were experiencing low confidence and motivation.
- All interviewed clients had experienced frustration and/or fear when attempting to engage with Work and Income.
- Generally clients stated they accepted a referral to Workwise because they felt they had exhausted standard options and that it was low risk as they had little to lose. They appreciated the support of their GP when deciding to engage with employment support.

Clients' early outcomes

- Interviewed clients felt more hopeful, confident, motivated and supported to achieve their goals once they became involved with Workwise.
- GPs also remarked that their patients were more confident and motivated to manage their health issues.
- Clients were actively engaged in Workwise services and were undertaking employment-related activities, such as developing their CV, writing cover letters, training in interview skills, and searching and applying for jobs.

[2] The Ministry of Social Development's term "cohort trial" refers to their studies designed to examine what interventions and services assist different client groups with specific health or disability issues into employment.

- Of the thirty-four total clients accepted into Workwise services over nine months, five had gained competitive employment and six had enrolled in accredited study. These results are in line with outcomes from the Hamilton demonstration programme.

Partnership roles and relationships

- Workwise was the primary driver for the partnership at all levels, generally initiating communication relating to the programme.
- The Workwise employment consultant bridged clients and Work and Income through communication and providing support for the client to navigate Work and Income's system.
- Communication between GPs and Workwise employment consultants occurred face-to-face and by text or e-mail and was facilitated through the regular co-location of the employment consultant at each practice.
- Workwise also facilitated communication between GPs and Work and Income, when Work and Income requested discrete information such as clarification of a client's medical certificate.
- No changes GPs and Work and Income's direct relationship were observed.
- Duplication of services did not emerge as a concern. Work and Income's primary role is to provide financial support and additional products to clients, such as assistance to access childcare. They generally direct clients to employment but do not work intensively with them.
- Workwise' role is as a complementary specialist agency that provides intensive employment support for people experiencing complex barriers.
- The standard and integrated pathways (Figures 10 and 11) show that the key point of difference was Workwise clients were referred directly from their GP, instead of first being "well" then navigating Work and Income's system to access employment support.
- Work and Income frontline staff reported learning new ways of talking about employment as a result of being involved in the partnership.
- Privacy and consent remain critical barriers to information sharing between all parties; further investigation and clarification around the extent of law and implications for service delivery are needed.
- The referral preferences between health and welfare differ. GPs prefer broad referral criteria focussing on a person's employment needs, whereas Work and Income focus on an individual's benefit status, age, and diagnosis.
- Sustainability of the employment support services in primary care will require on-going funding. To address the differences in organisational focus and referral preferences, and to allow GPs to maintain focus on employment as a health issue, the Primary Health Organisation (PHO) should consider taking a role, alongside welfare and non-government organisations, in providing this funding and negotiating the referral criteria to suit both health and welfare needs.

Executive summary

Background

In October 2012 Workwise and Compass Heath PHO formed a partnership to implement a demonstration of integrated employment support with two volunteer general practices in Wellington. The Workwise employment consultants began delivering services at the first general practice in November 2012 and the second in March 2013. Two Workwise employment consultants were co-located at each practice one to two days per week. GPs referred patients who wanted employment support and who had an identified mental health issue. By June 2013 the employment consultant had a full caseload made up of clients from both practices. Work and Income also became a partner in December 2013 developing a cohort trial involving some of Workwise' eligible clients.

Evaluation goals and objectives

The goal of this process evaluation was to explore the creation and chronicle the evolution of a partnership model between Workwise, Compass Health PHO and Work and Income and the early impacts on individuals involved in the service. Specific evaluation objectives were:

- To examine the on-going implementation and adaptation of integrated employment support at the Wellington general practices.
- To identify and understand the current outcomes (e.g. staying engaged in the service, undertaking activities typical of a person seeking employment, employment if applicable) for individuals involved in the EBSE service.
- To understand practice and system characteristics that influence a patient/client's choice to participate in the integrated employment support service.
- To examine the establishment of the formal and informal roles of each partner involved in the Wellington demonstration programme.
- To examine how the role of each partner in the demonstration programme aligns to enable individuals to take steps toward employment.

Methods

This process evaluation utilised both qualitative and quantitative data. Key stakeholders from Workwise, Work and Income and the general practices were interviewed for their perspectives on the development partnership and the programme's progress. Five clients were interviewed about their decision to participate and remain in the programme, and some of their previous experiences when trying to access employment support. Descriptive statistics were used to analyse client demographics, diagnoses and employment-related activities.

Key findings

The primary finding of this evaluation was that through coordination and communication, GPs, Workwise and Work and Income began to address the system barriers experienced by clients with mental health issues wishing to pursue competitive employment.

Partnership

Workwise was the primary driver for the partnership at all levels, they generally initiated communication and explored ways to improve their coordination with the other agencies. The employment consultant's role was to bridge clients with Work and Income through communication and providing support to help the client navigate Work and Income's system. Workwise also had a critical role in communicating with the GPs, which was facilitated through regular co-location of the employment consultant at each practice. By having an established relationship with the GPs, the Workwise employment consultant was also able to facilitate communication between GPs and Work and Income. No changes in the GP and Work and Income's direct relationship were observed.

All stakeholders indicated that the roles of Work and Income and Workwise were different and that duplication of employment support services was not an issue. Work and Income's primary role is to provide financial support and direct clients to employment, through their contracts and networks, but they generally do not work intensively with clients. Workwise' role is complementary, as through their specialist services they are able to provide intensive employment support for people experiencing complex barriers. As demonstrated by Figures 10 and 11 on pages 55-56, the key difference between the organisation's roles was the pathway to access employment support. The standard pathway relies on the person becoming on well first, then accessing support through Work and Income complex system where there is a high risk of information loss and time delays. In contrast the integrated pathway to access employment support is more direct, with a reduced risk of information loss or delays. The integrated pathway enabled GPs to have a health-focussed conversation with their patient and provide them with coordinated support with the employment consultant. Additionally, as a result of observing the employment consultant frontline Work and Income staff are changing the way they talk about employment to all their clients, improving their service delivery generally.

Client outcomes

Clients enrolled in the programme demonstration reflected the population demographics of the Wellington practices' geographical areas which also had high unemployment rates. All clients had experienced mental health issues and diagnoses included depression, anxiety, bipolar disorder and schizophrenia. The majority of clients were receiving a Sickness Benefit at the time of enrolment. The precipitating reason that individuals were receiving a benefit, i.e. whether it was a physical or mental health issue, was not recorded. A number of clients who were not receiving benefits at the time of enrolment were "benefit appropriate". The number of Workwise clients eligible for the cohort trial was small because they reportedly did not meet the long-term benefit status (≥52 weeks continuous) criteria or chose not to participate. Five of the thirty-four clients accepted into Workwise services to 31 July 2013 had gained competitive employment and six had enrolled in accredited study.

All interviewed clients stated they were experiencing low confidence and motivation prior to enrolling in the demonstration programme. These issues in addition to the complex system and discrimination clients received from frontline staff, resulted in frustration and/or fear when clients tried to access support through Work and Income, which had. As a result of their high frustration levels, the clients felt they had nothing to lose when

accepting a referral to Workwise, particularly as their GP was supportive. After enrolling in the programme, clients reported they felt more hopeful, confident, motivated and supported to achieve their goals. Clients were regularly employment-related activities, such as developing their CV, writing cover letters, training in interview skills, and searching and applying for jobs.

Issues to consider

Continued co-location and integration within the general practices is critical to ensuring on-going high referral rates and developing relationships between the employment consultant and the GPs. As neither practice reported regular staff meetings, additional methods to share information about supported employment and client progress will be important to continued integration and relationship development.

Relationships between GPs and Work and Income remain difficult. The lack of communication pathways and lingering frustrations about the type of information shared appeared to contribute to these difficulties. However, the health professionals in the Regional Health Advisor and Health and Disability Advisor roles are well-placed to begin addressing issues with individual GPs or through the PHO. Development of clear communication pathways, such as a dedicated helpline or e-mail services for health professionals, may further address issues by reducing delays and information loss.

Further investigation and clarification around the extent of health information privacy and consent laws, as well as implications for service delivery are needed to address information sharing barriers identified by all parties. Long-term funding and addressing GPs' and Work and Income's different referral preferences are key to ensuring programme sustainability. The PHO should consider taking a role in providing this funding and negotiating the referral criteria to suit both health and welfare needs.

Programme background

Intensive employment support using the Individual Placement and Support (IPS) approach to supported employment is also referred to as Evidence Based Supported Employment (EBSE). This approach has been shown to be highly effective in helping clients to achieve competitive employment when delivered in a secondary mental health multi-disciplinary team setting.

A recent meta-analysis of fifteen control trials demonstrated that people with severe mental health issues enrolled in IPS obtained competitive employment outcomes at an average rate of 58.9 per cent versus 23.2 per cent for the controls (Bond, Drake, & Becker, 2012). Educational and employment outcomes achieved with young people with first episode psychosis are even higher, at 69 per cent (Rinaldi, Killackey, Shepherd, Singh, & Craig, 2010). Intensive employment interventions aim to overcome individual level disadvantages and severity of disability or health issue. Evidence demonstrates that employment programme characteristics are often better predictors of successful employment outcomes than individual client characteristics (Drake et al., 2012).

The IPS approach is characterised by eight principles, with the first being a commitment to competitive employment as an attainable goal for clients. Non-competitive jobs such as sheltered employment, unpaid internships, set-aside work and volunteer jobs are not encouraged. The desire to work in a competitive job is the only requirement to accessing IPS; eligibility is based on client choice. Clients are not excluded based on work readiness, clinical symptoms, level of disability or involvement in the criminal justice sector. IPS programmes are also closely integrated with mental health services and the other service teams that are supporting the clients, facilitated though treatment team meetings (Drake et al., 2012). The IPS approach addresses the important issue of job matching for individuals experiencing mental health issues, as the evidence demonstrates that inactive individuals with pre-existing mental health issues experience more benefits with standard employment arrangements than with a temporary job or a job with long hours (The Organisation for Economic Co-operation and Development (OECD), 2008).

Employment support is individualised based on client preferences and needs and the job search process accounts for these, along with a client's strengths and work experiences. Job search is rapid to help clients obtain jobs promptly rather than after lengthy pre-employment assessment, training or counselling. Job placement is further facilitated by the employment specialist by building relationships with local employer networks in the area of the client's interests. This systematic job development and searching for jobs through these established networks is more effective than self-directed job searches. Finally, support is always individualised and time-unlimited. Supports are available for the client at any stage in their employment journey as long as the client wants and needs the support. A fidelity scale is also used to measure the degree to which services implement principles and provide areas for self-assessment and improvement (Drake et al., 2012)[3]. Fidelity to EBSE principles is a key predictor of employment outcomes (Drake et al., 2012).

[3] For more information visit: www.tepou.co.nz/ebse

The first EBSE programme in a primary care setting in New Zealand was established in February 2012 after Workwise received funding from Work and Income Waikato to provide employment support for people experiencing mental health issues to return to or stay at work. This demonstration occurred in partnership with three general practices belonging to the Midlands' Health Network Primary Health Organisation. Key findings from a formative evaluation of this implementation showed that integrated employment support to assist people with mental health issues to return to work is feasible in general practices. It also showed that the service was valued by GPs, enhanced the employment focus health consultations and provided an evidence-based intervention as an alternative renewing sickness certification, extending their work incapacity (Te Pou, 2013). Additionally, the evaluation showed that high levels of integration were important to maintain referrals, and the commitment of senior leaders from partner organisations was important to the establishment, implementation and on-going sustainability of the demonstration.

Drawing on the success of the Waikato demonstration, Workwise and Compass Heath PHO invited interested general practices to implement a similar demonstration in Wellington. The lead GPs from two practices, Newtown Medical Centre (Site A) and Waitangirua Health Centre (Site B), agreed to participate and provide a consultation room for an employment consultant to provide employment support services at their practices. Funding for the initiative was provided through a grant from the Wise Group. Workwise informed Work and Income of the initiative and together they decided the demonstration programme would be a part of the Ministry of Social Development's (MSD) cohort studies. This would seek to understand what works to support people who have experienced mental health issues to return to work, particularly people who have been benefit recipients for a long time, and the role of Work and Income in providing this support with Workwise.

MSD wanted to identify and explore the set up and effects of models that provide evidence-based supported employment services in primary care, and understand Work and Income's role in supporting people who are long term benefit recipients to return to work. In line with this goal MSD contracted Te Pou to evaluate the partnership between Work and Income, Workwise and the general practices. The goal of the evaluation was to examine the implementation of the partnership and explore early outcomes for clients involved in the demonstration.

Evaluation approach and method

Process evaluation examines the implementation of the programme. It focuses on describing and documenting the activities which are occurring, whether the programme is being implemented the way it was planned, and if there are problems in the implementation. The evaluation approach, including data analysis and reporting, has been informed by a brief review of the partnership literature, as well as the evaluation team's ongoing contact with the programme and engagement with key staff and other stakeholders. It was underpinned by utilisation and programme theory-driven methodologies, which are outlined in more detail in Appendix B.

The goal of this process evaluation was to explore the creation and chronicle the evolution of a partnership model between Work and Income, the GPs and Workwise, and the early impacts on individuals involved in the service. Specific evaluation objectives were:

- To examine the on-going implementation and adaptation of integrated employment support at the Wellington general practices.
- To identify and understand the current outcomes (e.g. staying engaged in the service, undertaking activities typical of a person seeking employment, employment if applicable) for individuals involved in the EBSE service.
- To understand practice and system characteristics that influence a patient/client's choice to participate in the integrated employment support service.
- To examine the establishment of the formal and informal roles of each partner involved in the Wellington demonstration programme.
- To examine how the roles of each partner in the demonstration programme align to enable individuals to take steps toward employment.

These objectives were developed by the Te Pou evaluator, in consultation with the evaluation staff at Knowledge and Innovation (MSD). Workwise reviewed and provided feedback on the proposed objectives before they were finalised.

Data collection methods

The data collection methods included a brief literature review, in-depth interviews with key stakeholders and clients, and a review of routine programme data from Recordbase, Workwise' data collection and management system. Additionally, site visits to the participating general practices and two relationship surveys targeted to Work and Income frontline staff and GPs were conducted.

Literature review

A brief review of partnership literature was conducted to inform the interview schedule and relationship survey design. The review was primarily conducted as an internal working resource to inform this evaluation 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 and clients during June and July 2013. Key stakeholders involved with the management and delivery of the programme were interviewed. These stakeholders included strategic and operations staff from Workwise and operations and frontline staff from Work and Income. Frontline Work and Income staff interviewed were from the branches local to the practices and were selected to participate by their branch manager. Interview participants included two GPs, five representatives from Workwise and thirteen from Work and Income. Two additional GPs and two nurses chose not to participate in formal interviews, citing a lack of time. However, they did briefly comment on the programme, and their perspectives were taken into account during the analysis and interpretation of the data.

Semi-structured interview schedules (see Appendix D) were used to allow the interviewer to follow up the conversation as needed. Generally topics were guided by the relevant literature and designed to understand the partnership. Topics included the formation of the partnership, the goals of the programme, management practices in implementation, and understanding communication between the partners at all levels, as well as within Workwise and Work and Income. General information about their individual roles, the roles of each organisation and work processes relating to the support of clients was also sought. Interviews ranged between ten and forty-five minutes, with the GPs generally only able to participate in the shorter interviews. Each key stakeholder interview was conducted at a time and place that was convenient to each participant, generally their place of employment. All interviews were recorded and fully transcribed to facilitate data analysis.

All clients enrolled in Workwise services before mid-June 2013 consented to have their information used in the evaluation. Five client in-depth semi-structured interviews were also conducted. Interviewees were selected in consultation with the Workwise team leader and employment consultant and included males and females from ages approximately 20-60 years with a variety of backgrounds and experiences. Topics discussed included their decision to accept a referral to Workwise, their background and employment experiences, their relationship with Work and Income and their relationship with Workwise.

Review of routine programme data

Recordbase[4] 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 employment consultants throughout that person's involvement in the programme. Data describing client demographics, activities, early outcomes and experiences are described beginning on page 23.

Data analysis

Interviews were audio recorded and transcribed with pauses and irrelevant words removed. Inductive and deductive analysis was conducted and a set of 15 codes was developed based on the content of the interviews. Descriptive statistical analysis was conducted on the Recordbase data and on the survey response data. For more

[4] http://www.wildbamboo.co.nz/

information on inductive and deductive qualitative data analysis and descriptive statistics, please see Appendix B. Te Pou evaluators adhered to the usual standards of professional conduct and research ethics procedures. All interviewees were provided with an information sheet detailing the nature of the evaluation and signed a consent form agreeing to participate.

Limitations

The evaluation findings presented have been derived primarily from a limited number of key stakeholder interviews, the relationship surveys and the analysis of Recordbase data. Where possible, the data was triangulated with available routine programme and client data to improve the internal validity of the findings reported. These small samples may limit the generalisability of the findings. Clients who chose not to be referred or who stopped engaging in the service were not able to be contacted to obtain their views. The response rate for the follow-up survey was low; therefore any relationship development that occurred outside of respondents would not have been captured. Additionally the evaluation was conducted in the early stages of programme implementation, five to seven months after the employment consultants began at the practices.

Establishing the partnership

As noted in the programme background on page 13 in October 2012 Workwise, Compass Health PHO and two general practices decided to implement an integrated employment support programme in Wellington. While both practices are a part of Compass Health PHO, they are owner-operated by the lead GPs and operate on a traditional for-profit business model. GPs operating in this model generally have a degree of autonomy in determining the health services available at their practice, including those delivered by other health providers. The lead GPs at each practice have an interest in the social determinants of health and wished to offer their patients an evidence-based alternative to signing them off work via the traditional medical certificate. This interest, combined with the Workwise and Compass Health CEOs "clearing the way" for staff to be involved, enabled the programme to get underway quickly.

As indicated below in Table 1, a 0.5 FTE employment consultant was established at each practice within a few months of the initial agreement. In late 2012 Workwise invited Work and Income to become involved in the demonstration and a new cohort trial in 2013. A staff change occurred in May 2013 when the Newtown employment consultant left. Subsequently the Waitangirua employment consultant was appointed full-time and took on the caseload for both practices. By the end of July 2013, the programme had reached capacity and Workwise created a waitlist for new referrals.

Table 1: Key implementation milestones

Date	Milestone
October 2012	Workwise and Compass Health CEOs agree to implement employment support in primary practices
November 2012	Employment consultant role established at Newtown Medical Centre
December 2012	Work and Income become involved
February 2012	MSD cohort study referral process established for eligible Workwise clients
March 2013	Employment consultant role established at Waitangirua Health Centre
April 2013	Te Pou begins evaluation of demonstration programme
June 2013	Personnel change: Waitangirua employment consultant adds caseload from Newtown practice
June 2013	MSD cohort study extended to end September 2013
July 2013	Workwise caseload full, waitlist for new referrals created

The total enrolled population of the two medical centres is 14,109[5]. As demonstrated below in Table 2, site characteristics of the practices vary, as they are located in different areas of the greater Wellington region and serve different populations. Site B is located in a low socio-economic area with a large number of patients with high needs, many of whom are unemployed. Site A is a much larger practice with a mixture of ten full and part time GPs working at the practice. The cultural mix of Site A is predominately European, compared to the high proportion of Māori and Pacific Islanders at Site B.

[5] Correspondence with Compass Health PHO practice liaison

Table 2: Practice and catchment area characteristics

	Site A	Site B
Medical centre staff	11 GPs, (7 FTEs), six nurses (5 FTEs), and seven other staff.	Five GPs (3.5 FTEs), four nurses (3 FTEs), and four other staff.
Overview of caseload[6]	A mixed demographic population, with approximately 20% Māori and Pacific Islander and a significant proportion of Somalis and people from the Indian subcontinent. There are many poor patients living in Council and assisted housing. The practice has about 9500 registered patients.	A busy practice in a low socio-economic area with a high ratio of Māori and Pacific patients and many high-needs patients. The practice has approximately 6000 patients on the books.
Cultural diversity[7] of enrolled patients	60.2% European 9.5% Māori 10.5% Pacific people 12.9% Asian	19.5% European 24.8% Māori 46.5% Pacific people 6.3% Asian
Unemployment rate[8,9] of geographical area surrounding practice	6.4% for people aged 15 years and over	14.4% for people aged 15 years and over
NZDep2006 deprivation profile[10] of geographical area surrounding practice	65% of population is in deciles 7-10 (decile 10 is most deprived)	96% of population is in deciles 9-10 (decile 10 is most deprived)

[6] Information from each practices' lead GP

[7] Compass Health PHO

[8] Wellington region unemployment rate is 5.2%

[9] Statistics New Zealand 2006 Census Data

[10] Calculated using meshblock data from Statistics New Zealand 2006 Census Data

Integration and enrolment

Both practices have been actively referring clients. As demonstrated in Table 3, between October 2012 and July 2013, a total of 45 people were referred to Workwise. Twelve of the fifteen GPs referred at least one patient and the referral rate per GP was between three and four patients. Thirty-four of the 45 people referred had been accepted by Workwise. All of the 11 people referred by GPs from Site B had been accepted, compared to a general acceptance rate of 68% (23) from Site A.

Table 3: Employment consultant integration with the two sites and referral data October 2012 to July 2013

Referrals	Site A	Site B
Total number of referrals made	34 total referrals Nine out of ten GPs referred 27 people.*	11 total referrals Three out of five GPs referred 11 people
Referral rate per GP	3.0	3.7
Acceptance	68% (n=23) of referrals were accepted; 26% (n=9) were declined; and 6% (n=2) were pending	100% (n=11) of referrals were accepted
Proximity		
Co-location	Present one morning per week	Present one day per week
Contact	The employment consultant has informal contact with the GPs working at the practice on the day on which they are located at the practice. Formal meetings are arranged as necessary.	The employment consultant usually sees at least one GP informally during their day at the practice. Formal meetings are arranged as necessary.
Note: Seven referrals from Newtown did not have any GP information		

The employment consultant is co-located at Site A one morning per week and is co-located at Site B one day per week, down from two days per week to reflect the caseload size from that practice. It is likely that some of the differences observed across the sites are a reflection of the number and demographics of the area population, as outlined in Table 2. The programme has been available at Site B for less time than at Site A, which may account for the lower referral rates.

Co-location has been a challenge at Site A, due to renovations being carried out on the building. However, all parties, including Work and Income, have been pro-active about finding workable solutions. As noted by a Workwise representative, integration and relationship development in a general practice setting may require more time and effort than traditional co-location in secondary care multi-disciplinary teams, as the GPs may be on a sessional basis and the employment consultant may not see each GP regularly.

When the trend of accepted referrals per practice over time in Wellington is compared to referral rates for Waikato as in Figure 1, it is apparent that referral rates from Wellington are rapidly increasing over the nine

month period, though this may slow as the employment consultant's caseload becomes full. The data for each programme is presented from the beginning of the programme (month 1) through to the end of July 2013. Waikato demonstration began in February 2012 while Primary Health Wellington begins in November 2012. One of the GPs from Site A has been the referring clinician for just over half of the referrals, which may account for the significantly higher numbers.

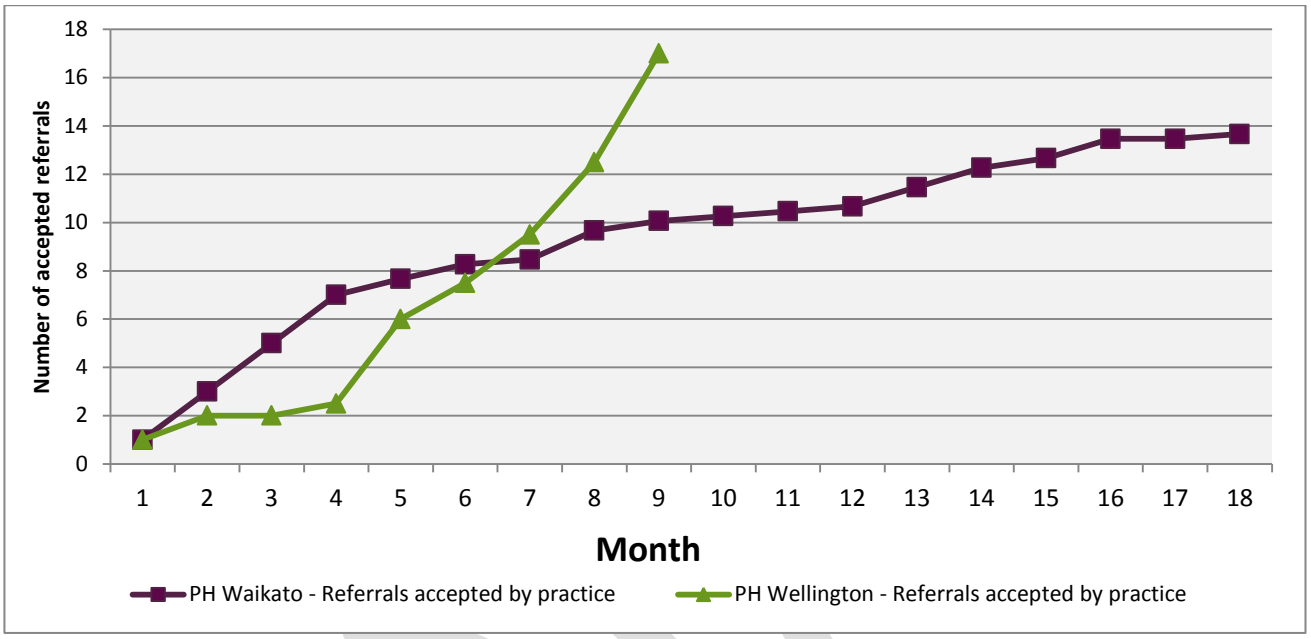

Figure 1: Referrals accepted to July 2013, Hamilton v Wellington

Referral process

The GPs stated they were open to discussing employment at any appointment, but that it was typically precipitated by a patient's medical certificate request. One of the GPs noted patients discussed their aspirations and difficulties, but found that patients often had become marginalised and removed from the workforce, making it challenging for them to return to work quickly. The GP indicated they also offered a Workwise referral to people who were not working or were considering stopping work due to redundancy, a recent job loss or other stresses. The GPs did not have any structured screening criteria—they simply asked the patient whether or not they were interested. The patient would choose to attend the appointment or not.

> *You're [the patient is] never going to say whether you like it or not, you're going to turn up and go see them [Workwise]. …More or less if they wanted to go I would refer anyone.* (GP1 Site A)

The GP noted that most patients were willing to engage in a conversation around employment and were interested to hear that an organisation was available to help them *"bridge that gap between joblessness and employment*". They related that only a few people had not been willing to consider a referral to Workwise. These patients had typically tried to return to employment and had experienced failure and did not want to try again. Some had become used to their lifestyle or were on the Methadone Maintenance Programme or found it hard to relate to society. Despite the hurdles that these patients were experiencing, the GP noted that some patients were beginning to shift and become more open to the idea of accepting a referral to Workwise.

> *There were hardly any I think who said, "no I don't want to do that at all". I was surprised—there were a few people who had been in such a depressive state for a long time and they were quite happy to have a chat.* (GP1 Site A)

Another GP stated that people often needed support to gradually return work. They needed the right type of job and employers who were willing to employ them. The GP expressed concerns that there might not be a lot of jobs available for this group, which could be a barrier to returning to employment. Generally the GPs reported that the referral process was quick and easy and that they were excited to have the opportunity to have a positive conversation about employment with patients, as previously these conversations could be a source of frustration for both parties.

Cohort trial

A subgroup of the Wellington Workwise clients were accepted into the MSD cohort trial, which was designed to provide intensive wrap-around services to assist a client experiencing a mental health issue back into employment. Work and Income indicated that these services included a close examination of a client's situation, linking the clients to other organisations and providing assistance around issues such as access to better housing or childcare. Initially this cohort trial was targeted at clients aged 18-39 and "long term beneficiaries" who had been on a Sickness Benefit continuously for at least 52 weeks or on an Invalid's Benefit. Most of Workwise' clients are also Work and Income clients or are eligible for benefits, though only a few of them met the long-term benefit criteria. Clients who met the criteria were offered the opportunity to participate and could choose whether or not to be involved. Due to a lack of participants, the age range was expanded to include clients who were 18-49 years old and the trial finish date was extended from June until 30 September 2013.

Client demographics, activities, outcomes and experiences

This section analyses data for the thirty-four clients enrolled in the Workwise programme. It includes clients' demographic profile, early outcomes (e.g. staying engaged in the service, undertaking activities typical of a person seeking employment, or employment if applicable) and interviewed clients' experiences in the programme.

Client demographics

This section describes the characteristics of clients with respect to their age (in years), gender, ethnicity and mental health diagnosis. The clients' length of stay in the service, the different activities the clients undertook with their employment consultants, and the time spent in each phase are also described in this section. These information extracts were taken from Recordbase, Workwise' client data collection and management system.

As shown below in Figure 2, of the 34 clients accepted in the period between October 2012 and July 2013, more than 60 per cent are males. The mean age of accepted clients is 37 years old. The youngest client is a 19 year old female and the oldest client is a 56 year old male.

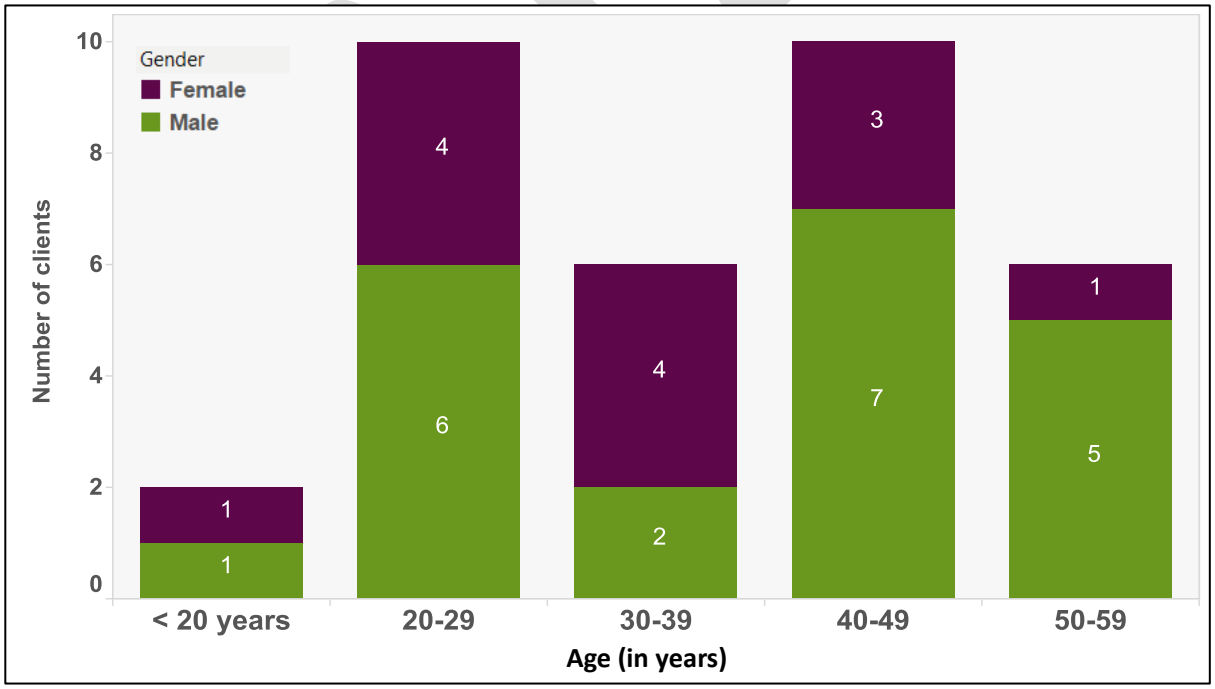

Figure 2: Age (in years) and gender of accepted Clients, October 2012 to July 2013

As shown in Figure 3, 19 (56%) of the 34 accepted clients are NZ European/Pākehā and most of them are enrolled at Site A. Seven of the nine clients who identified as Pacific Islander are enrolled at Site B. There were only two Māori clients. Four clients were labelled as having "Other" ethnicity which includes other European, Australian and "other" with no additional description.

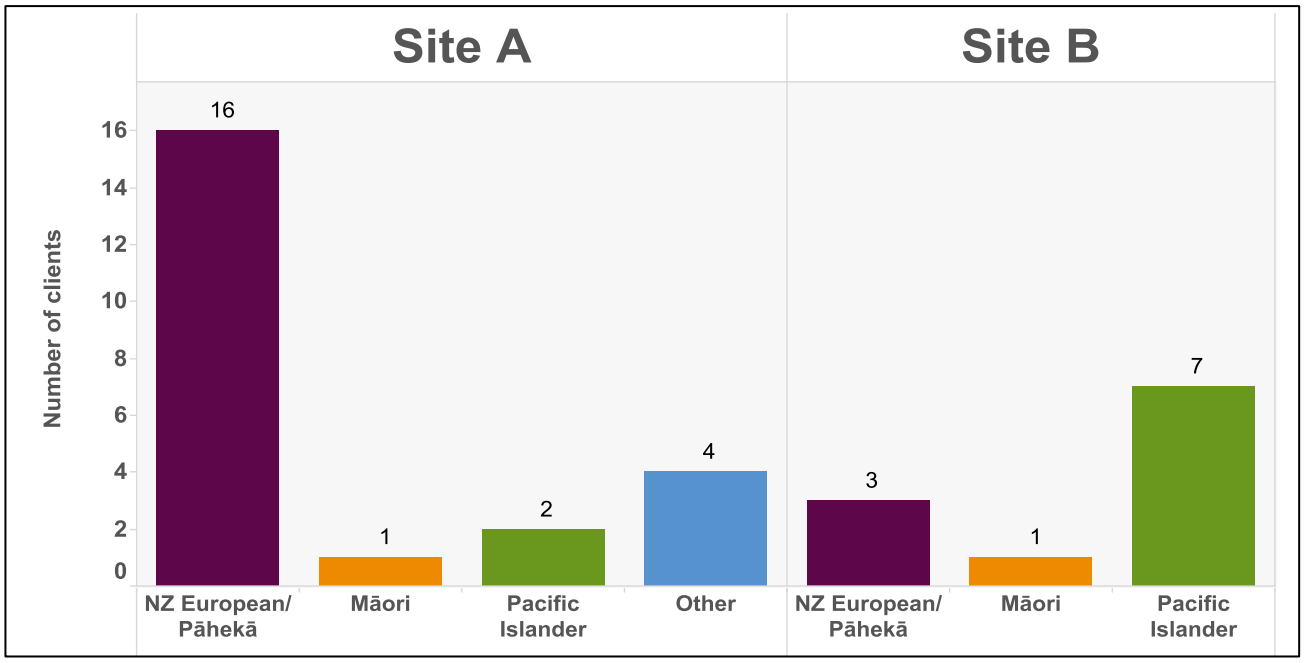

Figure 3: Ethnicity of accepted clients, October 2012 to July 2013

Clients' mental health diagnosis was recorded on the referral form and/or self-reported. To conform to standard diagnostic categories clients' mental health issues were classified according to the seven diagnoses as seen in Figure 4. Of the 34 accepted clients, 16 (47%) experienced depression, nine (26%) clients experienced an anxiety disorder and five (15%) experienced bipolar affective disorder. Two clients reported having had experiences of stress and these were classified under "Other". Records of nine clients (26%) showed that aside from their mental health issue, they also experienced co-occurring (co-morbid) health conditions such as diabetes, epilepsy, ADHD, head injury, chronic back pain and gout. Depression was the primary mental health diagnosis for five of these clients. The most frequent diagnoses of clients are in line with the most common self-reported diagnoses of adults in the 2012 New Zealand Health Survey.

Figure 4: Mental health issues of accepted clients, October 2012 to July 2013

Each client may report their benefit status to Workwise at their initial return to work assessment. Of the 18 clients whose benefit information was recorded, 14 were receiving a Sickness Benefit, two were receiving an Invalid's Benefit and two were receiving an Unemployment Benefit. The precipitating reason that individuals were receiving a benefit, i.e. whether it was a physical or mental health issue, was not recorded. Records show that several clients, with the support of Workwise, were applying for benefits or other financial assistance, such as an accommodation grant. After becoming involved with Workwise, at least one client transitioned from a Sickness Benefit to an Unemployment Benefit. One client transitioned off benefits entirely after obtaining employment.

Upon entering Workwise' service, the length of time that an individual has been out of employment is recorded. Records indicate that of 24 clients, 16 (67%) had been unemployed for two years or less. Seven clients (29%) had been unemployed between two and five years and one client had been unemployed for more than six years. The clients' demographics and benefit, unemployment and diagnostic history are reflective of the employment support programme's target group, which are people from high needs populations who face complex barriers to employment, including a lengthy absence from the employment market and experience of a mental health issue.

Client activities and outcomes

This section describes the activities that clients undertook after becoming involved with Workwise and both programme and individual employment outcomes.

The length of stay in the service (in months) from the day they were accepted to the service, up to the 31st of July 2013, was computed for all the 34 accepted clients. Adjustments in the calculations were made for the four clients who were discharged, using their discharge date instead of 31 July to calculate how long they were in the service. The length of stay (in months) of clients ranged from less than one month (for nine clients) to almost eighth months (for two clients). Figure 5 shows the distribution of clients according to how long (in months) they have been in the service, to the type of employment activity they were involved in as of end of July 2013.

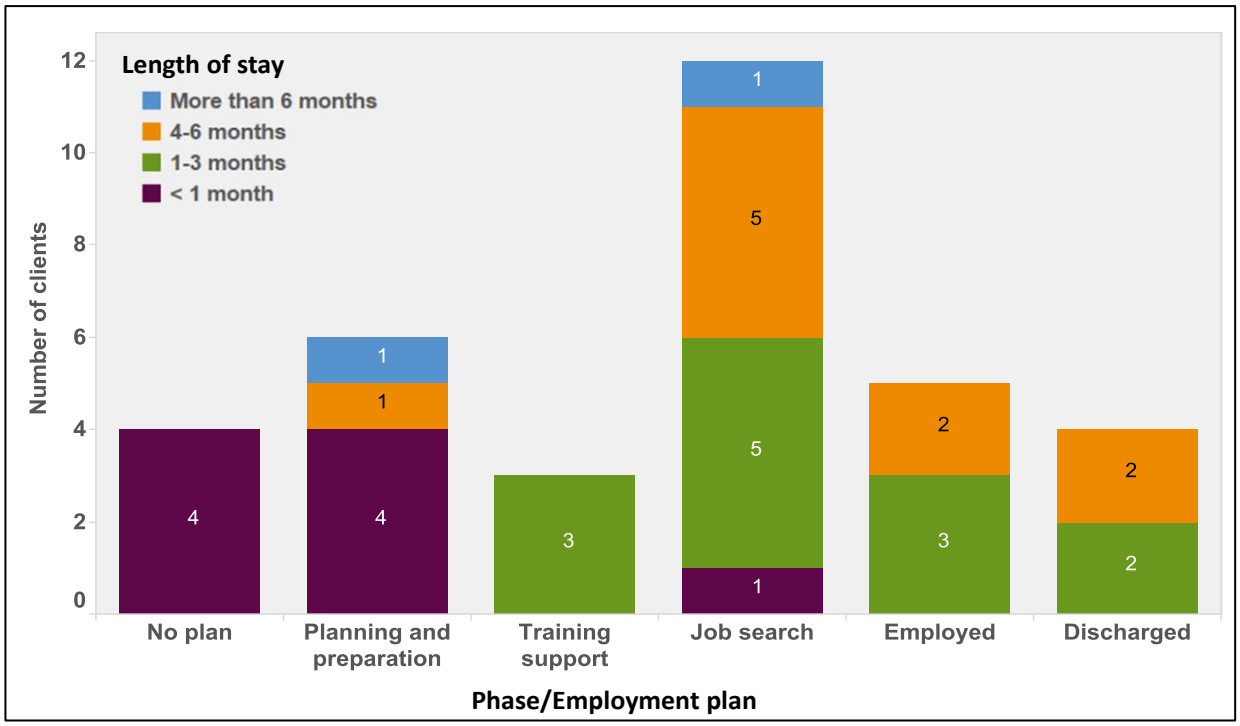

Figure 5: Length of stay in the service of accepted clients by phase

It is expected that among new (less than one month) clients in the service, there would be clients who have no employment plans yet or who are in the *planning and preparation* phase. One client was job searching at this early stage. This was in line with the fidelity of evidence-based supported employment, which aims to start job search, on average, within 28 days of referral (Drake et al., 2012).

After the first month in the service, clients typically entered the *planning and preparation* phase, which includes employment planning activities essential to job searching. Most clients entered the *job search* phase within one to three months after enrolling in the service. The three people in the *training support* phase are clients who enrolled in accredited study courses. Of the five people employed, three clients were in employment within three months of enrolling on the service, and two others were employed after four months of being accepted into the service. These figures are in line with IPS, as studies demonstrate that on average clients gain competitive employment after four and a half months, but much faster than standard vocational rehabilitation programmes, where on average clients gained competitive employment after almost seven months (Bond et al., 2012). Four people were discharged; one because they could not be contacted, one did not engage in the service as demonstrated by non-attendance, and two voluntarily opted out of the service choosing to continue their employment search on their own.

Figure 6 shows the employment outcomes to July 2013 (month 18). The starting month in Figure 6 is February 2012 for Hamilton while it is November 2012 for Wellington. Over the 18 month period a total of 29 people from the five practices (approximately six per practice) started work in Hamilton. Some of these individuals have had more than one job, which is common for intensive employment programmes that support people through multiple jobs. Although employment outcomes were initially slower for the Wellington group, by month nine (July 2013) the employment outcomes are in line with the Hamilton group.

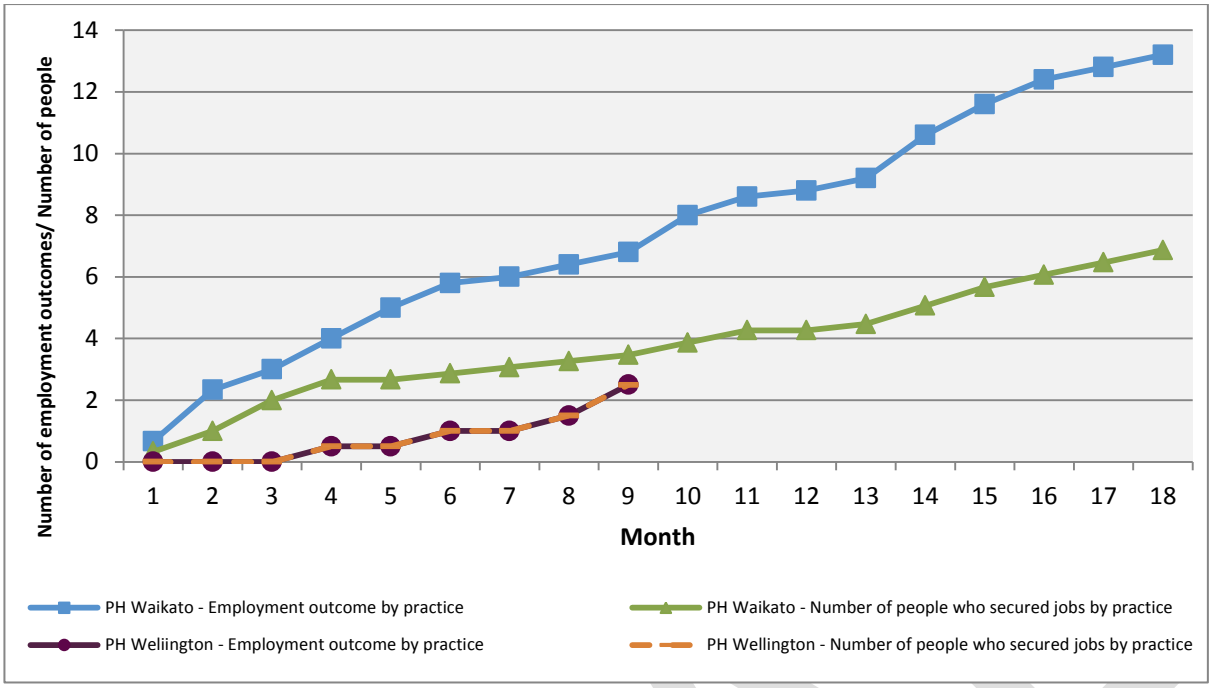

Figure 6: Employment outcomes to July 2013, Hamilton vs. Wellington

Of the 34 accepted clients in Wellington, five individuals (15%) were able to find employment between February and July 2013. As demonstrated by Figure 8 below, all of them were working 40 hours a week except for the shop assistant who only worked four hours a week. These clients continued to receive support from their employment consultants through phone calls, home visits, or visits to the Workwise office.

An additional six clients from the Wellington demonstration enrolled in an accredited study course. Two of them enrolled in a computer course, one in a clothing and design course, one in a New Directions course and two in courses at Whitireia New Zealand.

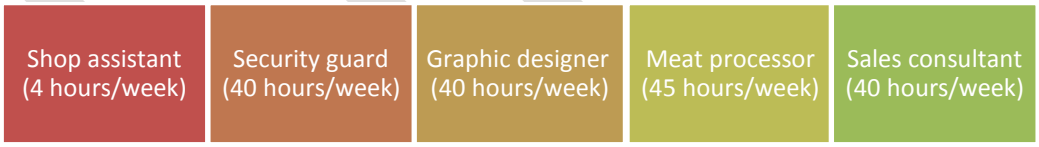

Figure 7: Job titles and number of hours worked per week of the five Wellington clients

Client experiences

Interviews were conducted with five clients who shared their experiences about the programme and Workwise services so far. All five clients had been unemployed for one and five years prior to enrolling with Workwise. All clients were previously employed or involved in study, though their reasons for being currently unemployed varied. Some stated that it was related to physical disabilities or injuries, others cited mental health issues, and some clients mentioned both.

Many of the interviewees talked about previous bad work experiences, which left them feeling dejected and frustrated.

> *I got kind of ripped off [in my last job]. The guy who was training me left and they didn't replace him and that kind of worked me into the ground.* (Client)

One young client had dropped out of a tertiary course, becoming "mixed up with the wrong crowd" and then losing confidence.

> *I was 17 when I left school. I was sick for a while, and then when I got better I thought I would try a nursing course, but it didn't go so well. And ever since then I lost confidence in myself. …I thought it was cool not to go back to doing another course, because I was doing a lot of drinking and stuff—that was why I left the course. I thought I was escaping from all the problems I was going through. Now I regret it.* (Client)

Many clients had tried to engage with Work and Income or other employment agencies previously, but were not satisfied with the results.

> *I got support from another employment agency, but it was through Work and Income and they were doing the same type of thing. They had a policy where they had a certain amount of time to get the person a job and they weren't looking past my arm [injury] and trying to get me a job just to fulfil that policy. And I wasn't so happy with that, I was just a name on a paper and just get that person that job in that time.* (Client)

Several clients described their experience of having to go to Work and Income as "scary", discouraging or unhelpful, particularly when they were told they needed more documents or information before their application could proceed. Clients frequently cited that having to repeat their story and information to multiple Work and Income employees was frustrating.

> *They are pretty hard to work with. There's hardly anyone working there anymore. You are passed on a lot.* (Client)

> *No one there [at Work and Income] who could help me with the benefit. I have seen different people every time. I felt lost as we went again through the same stuff as with the first person. I felt they don't really listen and take what I say into consideration.* (Client B)

For most of the clients, the GPs first suggested a referral to Workwise. One client learned about the service through a family member working in one of the general practices and another saw some information on the

internet and then contacted his GP. Clients decided to take part because they needed help to find a job, wanted to improve their employment opportunities and keep their mind active. Clients generally felt they had "nothing to lose" by trying out the Workwise programme and one young client talked about how it was important for to set an example for their child.

> *I'm trying to succeed for [my child]. Just because I have an injury it doesn't mean that you can't do nothing and that's what I want my son to learn when he gets older. I want him to give things a go, whether he can do them or not.* (Client)

All clients reported they had low confidence, motivation and hope before they started working with Workwise. They stated they felt awkward staying at home, were worried about their ability to find employment, and were scared about potential changes in their benefit status. All clients reported that GPs were supportive of the decision to take part in the programme, though they were sceptical at their first appointment, unsure if this experience would be any different than at other employment agencies.

> *I wasn't confident at all [about finding a job]; I thought that it's just another Work and Income.* (Client)

Clients reported they felt "better", more positive and "excited about life" after working with the employment consultant. They felt they were "taken seriously" and employment consultants took the time to listen to them, encourage them and offer support. Clients stated that their experiences with the Workwise employment consultants were "what they needed" and were different because the consultants were not judgemental and believed their clients could find employment.

> *[The employment consultant] is a really cool person and I can tell [them] everything in confidence without getting chided or feeling embarrassed. …[They] actually listens and takes what I say into consideration, not like Work and Income. …I think if I didn't know [the employment consultant] I'd be struggling.* (Client)

When asked about the support provided by Workwise, clients mentioned activities such as developing or updating a CV, talking about potentially interesting jobs, encouraging clients to contact previous employers for references, or setting up job interviews. The employment consultants helped their clients with benefits paperwork and appointments at Work and Income, to help answer clients' benefit questions and speed up the process. When one client indicated some anxiety and concerns about attending an art course, the employment consultant offered to go with them to the art course on the first day to reduce their anxiety. One employment consultant also offered support if another client wanted to disclose their mental health issue to their employer. These practices reflect the focus on intensive support, particularly the need to support people to consider the issue related to discussing their mental health. These practices are in line with the delivery of evidence-based supported employment programmes.

Clients noted it is easier for them to deal with Work and Income now they have someone from Workwise to support them with their interactions. Some clients indicated they had less contact with Work and Income since becoming a Workwise client. One client interviewed was eligible for a benefit but had not applied before becoming involved with Workwise.

Having [the employment consultant] call Work and Income is helpful; if I was to do it [try to ring] by myself I wouldn't ring them. [The employment consultant] helped me get appointment ready so that I could go through the process faster and helped me filling out the forms. (Client)

One client who had returned to employment after more than three years of being unemployed was grateful for the offer of on-going support from a Workwise employment consultant.

Even though I came back [gained employment at his old company], [the employment consultant] still wants to keep in touch to see how things are going. (Client)

Clients said it was really important for the GPs to promote the programme to others. They were happy with Workwise services and said they would recommend others "give it a shot".

Three years after I lost my job and nothing. And look at [the employment consultant] they just came into the picture and look at me now, I'm working! I think all those people on the benefit need to go and see Workwise and they will quickly get a job. (Client)

The data in this section demonstrates that Workwise clients were representative of the patients enrolled at the two Wellington general practices, Site A and Site B. All had experienced mental health issues, including depression, anxiety, bipolar disorder or schizophrenia and most were on the Sickness Benefit, with a small number receiving an Invalid's or Unemployment Benefit. The five clients interviewed indicated they had tried to access support from Work and Income or other agencies but were largely unsatisfied and frustrated at time delays, repeating their story and the lack of results. They appreciated the support from their referring GPs and reported increased confidence and motivation after engaging with Workwise. They had strong relationships with the employment consultant and appreciated the individualised support they received, stating others who were unemployed or on a benefit would gain from Workwise' services.

Partnership

The partnership for this demonstration programme was developed at three levels across the different organisations of Compass Health and the general practices, Workwise and Work and Income. Figure 8 shows these levels included strategic management, operations management and frontline staff, including the GPs at the two practices. The division is not a strict hierarchy as at times staff from each organisation, particularly the GPs, Workwise team leader and Work and Income Regional Health Advisor (RHA), have worked at both an operational and frontline level. As outlined previously in partnership establishment, the strategic management was instrumental in establishing the programme.

Since the programme's establishment, the frontline staff and operational management have begun to develop relationships. Interviewees' views on the purpose and vision of the programme, how each organisation's role impacts how they work with clients, the challenges encountered, and the programme outcome and learnings are outlined in the following sections.

Figure 8: Organisational partnership levels

Organisational roles

To understand how each organisation could contribute to the partnership, it was important to establish each organisation's role and their understanding of how they could contribute to the purpose of the partnership. Respondents' views on this and the issue of duplication is outlined in this section.

Most Work and Income employees indicated that the main role of their organisation was to provide financial support.

> *With Work and Income we are the last resort to helping people with financial assistance, so if you lose your job or you become ill and there are no other alternatives that are available to you then you can come to Work and Income. You can get financial assistance that helps you meet your living costs, that helps you meet your housing needs and also to get you through.* (Work and Income staff member)

Interviewees also noted that Work and Income was broadening its focus, to become more needs- and work-focused in relation to clients, increasing access to employment support. One interviewee highlighted that a significant role of Work and Income is to provide employment support through accepting, managing and referring clients to vacancies. Generally frontline staff believed it was their role to help give clients information to identify and address their barriers, or find employment or training to improve their lives. This role was attached to an organisational goal of reducing long-term benefits dependency and improving their clients' well-being.

The focus on reducing long-term benefit dependency through employment was Work and Income's primary reason for becoming involved in the partnership through the cohort trial.

> *We need to look at the potential for a long term beneficiary receipt and invest a lot more in identifying the people with the more complex issues who can't work and to assist them if we can, because if they can get into work they usually will go quite well.* (Work and Income staff member)

The cohort trial was an opportunity to focus and develop their role as a screening agency for people on Sickness or Invalid's Benefits currently or at risk of becoming a long-term beneficiary. Work and Income needs to have a process to determine whether they or another specialist agency could provide the most appropriate employment support.

> *[Work and Income is] taking an investment approach and reducing the long-term liability of the people on the benefit and obviously one of the highest groups of liability is with Invalid's Benefit and those who are unwell. We need to have a better screening mechanism in place so that we can determine who it is that we need to work with [to directly provide employment services] and who we're likely to get results for. …Having a much better coordinated approach in terms of linking them back to employment when they are well and kind of managing their transition back into employment.* (Work and Income staff member)

Workwise' role is as a provider of specialised employment support integrated with clinical treatment, through the application of the Evidence Based Supported Employment (EBSE) approach. They typically work with populations who have complex needs and have experience helping clients in contact with secondary mental health services. Strategic managers at Workwise expressed that the purpose of partnering with Compass Health PHO and the GPs was part of their overall organisational strategy to extend the people they could reach and address the social determinants of health by reducing the impact of unemployment among people experiencing mental health issues being treated in primary services.

> *The early interventions drivers are really to shorten the period of time that people are distanced from the labour market. The longer that people are out of work then the higher the risk of developing health issues, mental and physical because of worklessness. Part of that process of early intervention is the desire for societal change and that is about turning the taps off in regards to people with mental health conditions slipping into worklessness.* (Workwise staff member)

The GPs were keen to participate and believed that offering early intervention for patients experiencing employment barriers or struggling to stay at work was a part of addressing the social determinants of health for their practice. A GP from Site A indicated that bringing Workwise into their practice was part of their overall desire to provide social support for their clients. They stated that the practice provides accommodation

assistance and legal help through The Citizens' Advice Bureau; providing employment support that also addressed mental health needs was a natural extension of their practice philosophy.

> *Workwise is right in there and have particular expertise with dealing with people with mental health problems. They were wanting to intervene early rather than people who were out of work for long, long periods of time and that they would have good staff that would cover both bases of dealing with mental health in relation to finding employment.* (GPA1)

Both Work and Income and Workwise believed their organisations had a common goal to improve the lives and well-being of people in New Zealand, which was a clear starting point for developing their relationship.

> *It's not just financial assistance; it's putting the steps for clients to achieve a better outcome for their lives; for better well-being.* (Work and Income staff member)

> *Everyone's got the same goal and aim at heart, which is about the health and welfare of the communities in which we work.* (Workwise staff member)

Despite the shared desire to help New Zealanders, it was clear that the organisations' perceptions and roles affected their approach to providing support to clients.

Working with clients: Work and Income

Typically, a Work and Income general case manager assessed and assisted clients when they walked into a branch. The client then either remained in the general pool to be seen by any available case manager or was assigned to a focused case manager. Case managers working in the general pool had never seen their clients before and generally had infrequent, if any, ongoing contact with the individual clients. They provided an initial screening when the client came in, which included finding out what type of benefit the client is receiving (if any), what kind of medical history and disability the client had, what kind of work they would like to do/could do and if they were able to work full- or part-time. The client's information then went into a queue before being added to a client's file.

Work and Income case managers highlighted some issues with the system. If a general case manager logged a job request, such as information/advice from the Regional Health Advisor (RHA), they were unlikely to receive the feedback. The new general case manager who picked up the job might have to go back and forth to understand what the information was for and the initial general case manager was left out of the loop. Another issue arising from this process was that often work was not picked up and processed in a timely manner, as only specific people could do some of the actions required in different processes. One interviewee felt that it would be ideal if the processes were structured in a way that all staff would be able to pick up the action from the notes made. The interviewee thought the planned changes of going back to client case management and caseloads would be an advantage when working with clients and other agencies within and outside the organisation.

In contrast, focused case managers have a caseload of clients and work with specific client groups, particularly people who have multiple barriers to returning to work. Clients assigned to focused case managers had the

opportunity to develop on-going relationships where the case manager understood the client's views and needs. However, caseloads were still high, with some focused case managers having caseloads of more than 100 people.

> *We look at what the client wants because at the end of the day, why are we forcing a client to do something they don't want to do? So you've certainly got to take into consideration what the client wants, whatever their views are at that particular time or whatever they are doing will be taken into consideration while we look at what we're doing with them.* (Work and Income staff member)

> *Once people have been here once or twice and have had good experiences, then that's fine, but you hear of other people having bad experiences because they're always vulnerable when they come.* (Work and Income staff member)

Once a client was fully assessed, their financial needs had been addressed and the client was well enough for work, the case manager might discuss employment with them.

> *Normally a client would have come in, assessed entitlement, a period of time will elapse, we'll get the financial side of it sorted out and they may or may not have a conversation about work, depending on what their health issues are. Then at some point down the track the case manager would have thought, "oh look, you're ready for work, let's see what vacancies we've got" and then spoken to a work broker.* (Work and Income representative)

The decision to refer the client to an employment agency was based on their needs; if they needed more support than Work and Income could offer, a case manager would consider referring them to another employment agency such as Workbridge, Work Mates, Providing Access to Health Services (PATHS) or Workwise. The frequency of referrals varied from once a day to once a month.

> *Once we've had a conversation with them about what they think they can do, then sort of saying, "do you think you'd want to speak to somebody about it? It's just a conversation to see what you're capable of doing and seeing what's actually out there for you" […] and then suggesting if they would like to talk to somebody who has a better idea of what the labour market is like out there. Then saying to them, "would you like me to refer you through? They're fantastic, they help people—that's their job" and then put the referral through if they're good.* (Work and Income staff member)

The programme coordinator, another Work and Income staff member, managed the referral process by sending a referral letter or email to the employment agency and either booking a two-hour appointment for a one-to-one meeting at Work and Income, or signing the client up for an in-house seminar held by the other employment agency. One interviewee stated they would contact the agency before referring a client to make sure there was not a long waiting list, and that the client was referred properly and actually met with the agency. The other employment agencies were seen as specialist services with the resources to support clients with higher needs and to provide on-going support beyond employment. One interviewee stated that if a client needed more support, they would be referred to Workbridge; if they were more confident and needed less support, they were referred to Work Mates.

> *…there are a couple of places, Work Mates, Workbridge they're the ones that we tend to use, referring them through to those organisations because they help people that have a disability or an illness and look at getting them back into some form of work so it's working alongside them as well. But it's also giving*

them different ideas and different places to look in terms of work and not scaring them. You know, a lot of people have actually been on the Sickness Benefit for an extremely long time. (Work and Income staff member)

Work and Income representatives highlighted that assessment duplications could occur between case managers, particularly those working in the general pool, or when referring clients to other employment agencies. This duplication occurred when clients' notes were incomplete and the new case manager had to repeat questions to fill the gaps. Assessment duplication between Work and Income and other external employment agencies occurred because limited information was shared at referral and sometimes the Work and Income case manager had either not received or not reviewed updates on a client's work process.

Work and Income had a limited role in liaising with and supporting employers. One Work and Income employee reported working with employers to discuss the possibility of subsidies for employing someone with a disability. Other employment agencies would also sometimes refer clients to Work and Income to discuss subsidies, although, according to the interviewee, this did not happen very often.

Interviewees indicated that actively supporting people on a Sickness or Invalid Benefit into employment was a new area for Work and Income employees. One interviewee reported that people on these types of benefits sometimes fall through the gaps. Another interviewee stated that Work and Income employees were not well qualified to deal with people on a benefit who experience mental health issues and they all would have to learn as they go.

Working with clients: Workwise

As a specialist employment agency, Workwise has a different approach to assessing and managing clients' employment needs. After a GP refers a client, they have an assessment with the employment consultant, who will continue to provide support to them throughout their relationship, serving as the client's primary contact person.

The Workwise employment consultant believed their role was to support clients with their goals to achieve a better life, describing it in the following way:

To get everybody, every single person into worthwhile living, employment, training, or whatever—I want […] clients to feel valued, to feel useful and to be happy […] my goal is to achieve that for everybody. (Workwise Employment Consultant)

Relationships between clients and Workwise employment consultants are developed slowly through weekly meetings and regular interaction using e-mail, text or phone. The employment consultant described how clients appeared more confident and hopeful after engaging with Workwise.

It's just fantastic to see people blossoming, people who don't want to get out of their pyjamas and then they [start to] look forward every week to coming to our appointments and to looking for work. They see me the first time and they're sort of head down and they don't want to talk. Then you see them the second time and they shake your hand. (Workwise Employment Consultant)

The regular work of Workwise employment consultants was described as being divided between looking for jobs and potential employers and contacting clients about potential jobs for them. The employment consultant reported that a lot of clients do not have access to the internet so they search for jobs on websites such as Trade Me or Seek using their work laptop.

> *…I also spend a lot of time emailing clients about jobs that I see like, 'what do you think? Here's a position that would be perfect for you, I'd love you to think about it!' I never say you have to apply. I say, 'what do you think? Would you like to apply? If you do please let me know and we'll discuss at our next appointment'… It's just being aware all the time of what position may suit that person—it's not going to suit everybody—just helping with little steps to work.* (Workwise Employment Consultant)

Workwise support is designed to be individualised and intensive. Employment consultants have small caseloads of approximately 20-25 clients. Figure 9 shows the different activities that the employment consultant undertakes with the clients. New clients, for instance, have initial meetings and appointments with their employment consultants (*Introduction and assessment*). As the clients start engaging with their employment consultant, they get support for the following activities: developing or updating their CVs and cover letter (*CV/Cover letter development*); receiving one-on-one training on interviewing skills (*Interview skills, training and support*); job search activities and community visits (*Job search*); sending out job applications, follow-up of these applications and client meetings (*Job applications*); actual visits to the employment site and undertaking job try outs (*Work experience and job try outs*); on-going support for clients who found employment (*On-going in-work support*); and client appointments or consultations with their GPs (*Clinical liaison/MDT*).

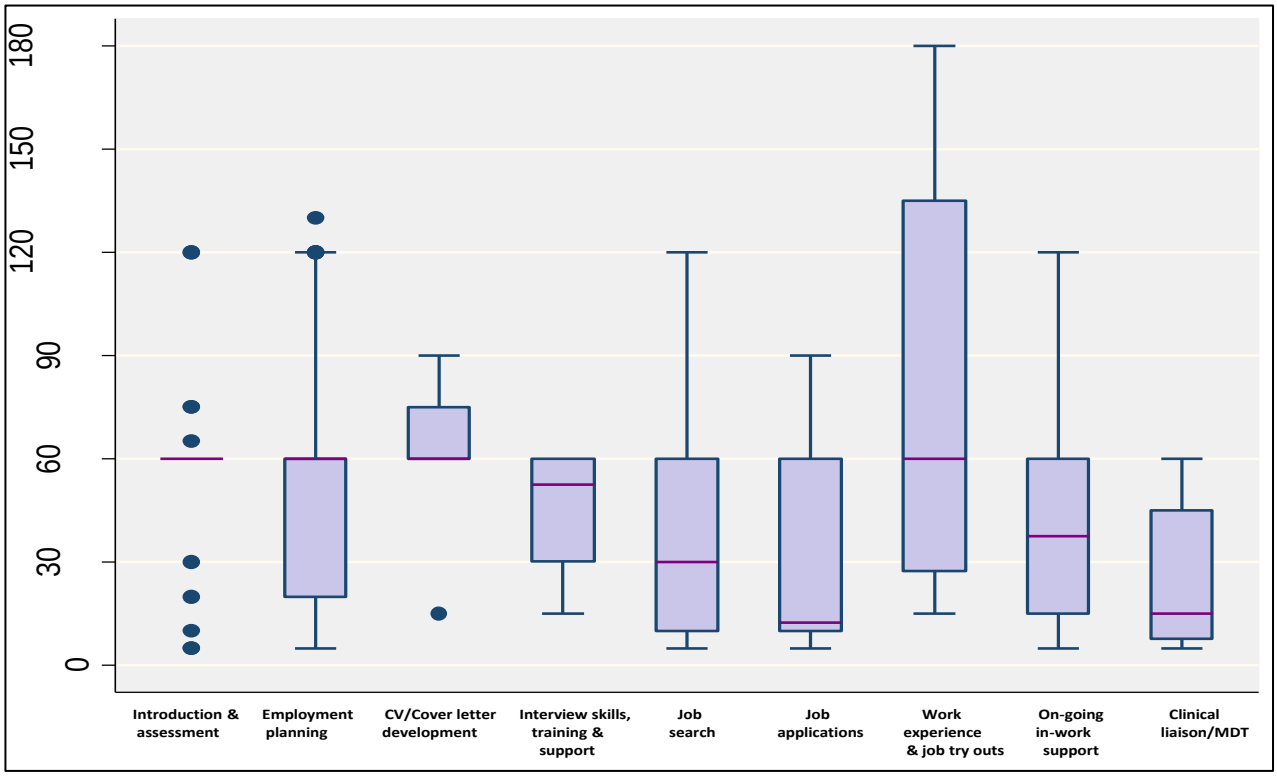

Figure 9: Time spent (in minutes) on activities, October 2012 to July 2013

The box plot shows the range of time spent (in minutes) of activities the employment consultant undertakes with the clients. The box for the *Job search* activities, for example, contains the middle 50 per cent of the data. The line in the box is the median (30 minutes) and it indicates that 50 per cent of the data (i.e., time spent for *job search* activities) is greater or lower than 30 minutes. The upper edge of the box indicates the upper quartile (60 minutes) and it means that at least 25 per cent of all time spent for *Job search* is more than 60 minutes. The lower edge of the box indicates the lower quartile (10 minutes) and it means that at least 25 per cent of all values are below this number. The "whiskers" demonstrate the minimum (5 minutes) and maximum (120 minutes) time values.

Many activities fall under *employment planning*, which describes the time that the employment consultant spends supporting clients with possible work opportunities and interesting jobs. This support was given by the employment consultant through meetings and appointments, phone calls and text messages, emails, assisting with paperwork, benefit counselling, helping the client research and gather employment information and setting up appointments for visits with potential employers. Sixty minutes was the most frequent amount of time spent on this activity, causing the median and the upper quartile to be the same value. The dots shown at the top of this activity represent outliers, indicating that some clients needed more time and support with these activities. The time spent on these activities ranged from 5 minutes (phone calls) to 130 minutes.

The employment consultant most frequently spent one hour providing clients with support to develop their CV and cover letters. Some clients required up to 90 minutes of support with this activity, as shown by the upper "whisker". The outlier of 15 minutes represents a phone call to one client for CV and cover letter support.

The employment consultant provided on-going support for the five clients who found employment. This occurred through meetings and appointments, phone calls, text messages and emails. Visits to the work sites of some clients, along with confirmation of employment and exit confirmation for clients who were discharged, were captured in the "*on-going in-work support*" activity shown on the graph. Time spent on these activities ranges from 5 minutes to 120 minutes.

The clients' needs determine the amount of time that the employment consultant spends on an activity. More than half of the total time spent on *introduction and assessment* activities was 60 minutes, demonstrated by the single median line on the graph. The other values were unusually higher or lower than 60 minutes and are shown as outliers on the graph.

The Workwise employment consultant indicated they took a proactive approach to job development and visited potential employers every day in order to get to know the work area and its businesses. They would spend about half a day 'cold calling' potential employers, searching the internet for available jobs or training institutions, and looking out for 'vacancy' signs when driving around. The employment consultant noted it was important to think about the nature of employment their clients were interested in as it was important to match the job to the client. However, the employment consultant also said they kept an open mind as an employment opportunity could arise that wasn't on the client's "list".

In addition to assisting clients to find and process information and undertaking the activities outlined above, the Workwise employment consultant spent time with the client's family, Work and Income and/or potential employers, to help them understand the client's needs and particular challenges.

> *There's a lot of things that we have to prepare and it's not a quick fix, "oh you've mentioned now it's time for you to go to work". It's not like that at all—it's about getting confidence back knowing that you've got someone, i.e. our consultants, that can find out information for you, find your passions, help you with financial assistance—be a go between with Work and Income if we have their privacy and consent.* (Workwise Employment Consultant)

The employment consultant and the client discussed the pros and cons of managing their personal information with employers and others, particularly disclosure of their mental health issue. When clients have disclosed their mental health issue to employers, the Workwise employment consultant is able to offer support directly to the employer.

> *I'll still check in with the employer—there is disclosure with the employer—who really appreciates our support and was quite impressed with the fact that we are still involved for [the client].* (Workwise Employment Consultant)

The employment consultant noted that clients with mental health issues often needed more support and care. People with mental health issues might miss Work and Income appointments because they did not understand the letter or forgot the appointment date. The employment consultant highlighted that some clients had difficulties keeping the job they were told they have to do, because they did not like it, but did not know how to tell Work and Income. Another Workwise employee added that the Work and Income environment often doesn't address the needs of clients with mental health issues, as Work and Income employees were often not aware they needed to work differently with this client group. Some clients start avoiding contact with Work and Income which can have negative consequences for the clients such as losing their benefits due to missing an appointment.

> *When it's a case manager who doesn't have that understanding of the health issue, that person is then put off contacting Work and Income and just shuts down. So they actually were eligible for some benefits and just never went for them so they just stopped contact or are very stressed by that contact.* (Representative of Workwise)

The Workwise employment consultant viewed their position as a bridge between the client and Work and Income as a critical part of their role. One interviewee noted that Workwise was in a key position to be a liaison between the client and Work and Income, to help address and prevent frustrations for Work and Income.

> *Having somebody to communicate with and support, from their [Work and Income's] angle they're obviously having the same difficulty from their side as the client is. They've got a group of clients that they're having a difficulty with in understanding and being able to support effectively. [Work and Income's] not moving them forward in a job and they're not moving them forward with their benefits either. It's just having that bridge to say, "okay this is how we develop and move forward".* (Representative of Workwise)

Duplication of services

Duplication of services can be a concern when partners have similar organisational roles. Interviewees discussed this issue and one Workwise representative noted that it was a risk as many Work and Income employment service contracts were managed nationally rather than regionally. However, due to clear differences in organisational roles and the ways that Workwise and Work and Income operate to support clients, it has not been a significant issue in this programme.

The key point of difference was Workwise clients were referred directly from the GP, instead of first navigating Work and Income's system before accessing employment support.

> *No I don't think there's duplication. I think the critical factor is that they're stationed at the GPs' and the GPs make the referrals and that's the key point of difference. For our work brokers to be picking up a client in that situation, the path that the client followed would have taken a lot longer, so we've shortcut that process.* (Work and Income staff member)

A case manager noted that another point of difference was Work and Income provided general rather than specialist support, such as that offered by employment agencies.

> *Work and Income are there to support clients into employment, [through] encouragement and financial support, but that actual handholding part–finding the jobs and supporting them while they're in employment—no.* (Work and Income staff member)

Many Work and Income case managers stated that multiple agencies may be able to provide clients with different employment or training opportunities.

> *There's no problem if a client does see another employment agency and then they get a lot more confident in their job search, there's no reason why they couldn't come back to see us and then ask to be referred to a job that's on our board. The more [clients] put themselves out there with different agencies, the more opportunities they may have to get a job.* (Work and Income staff member)

Operational and strategic staff from both Workwise and Work and Income identified that developing a process for Work and Income to accept client referrals for the MSD cohort trial also helped address potential issues of service duplication. On a theoretical level they identified that if Work and Income were providing intensive employment support to a client, Workwise would reduce their involvement. However, that had not occurred and Workwise continued to provide employment support to clients enrolled in the cohort trial.

> *From a practical level, if you walk past a window and there's a job in there and this person who you'd been working with for eight months wants me to put his CV in, I'm not going to not put his CV in for that job.* (Workwise staff member)

Developing relationships, communication and information sharing

Developing relationships between the organisations was a key component to forming the partnership. As outlined in the following section, relationships are beginning to form and are developing through communication and information sharing. The relationship between Workwise and Work and Income as well as each organisation's relationship with the GPs are outlined in this section.

Work and Income and Workwise

Workwise took the lead in relationship development, driving the interactions between themselves and Work and Income. As identified in IPS literature and through their own experience, the organisation knew they would be able to provide better employment support for clients through establishing and strengthening relationships with the local welfare agency.

> *On the hopes and dreams side, that's how I saw things progressing—is to improve [communication with Work and Income] from the client's perspective in a holistic way so the client has a bridge and a support when needed.* (Workwise staff member)

Work and Income believed that developing a relationship with Workwise through the cohort trial was an opportunity to link Workwise' employment support expertise with other services provided by Work and Income with the aim of offering more support to Work and Income clients.

> *We've worked collaboratively with organisations anyway, and we can't achieve results on our own. So our linkages and partnerships with other agencies are really critical so everybody can bring expertise. With the welfare reform it's a really good opportunity for us to be focusing on preparing those people [on a Sickness or Invalid's Benefit] for work and having a much better coordinated approach in terms of linking them back to employment when they are well and kind of managing their transition back into employment.* (Work and Income staff member)

At the frontline level of the partnership, relationships between Work and Income branch employees, including the programme coordinator and individual case managers, and work brokers was emerging. Relationship development occurred through providing support to individual clients. Staff communicated by phone, text, e-mail or face-to-face meetings. After obtaining the client's consent, the employment consultant would sometimes directly provide information to Work and Income to help progress a client's case or help Work and Income understand a client's history and illness.

> *[It's] passing on key bits of information in order for them to progress with that client… such as qualifications and contact information, correct confirmation of a birth certificate and driver licences about where that person lives, and if [Work and Income] don't have that, they can't move and progress and if they [the client] haven't provided it and couldn't provide it they were stuck. Pretty simple but could be quite devastating in that sense for that person not getting a benefit.* (Workwise staff member)

> *[I had some] queries about some medical forms that Work and Income haven't received back from the GP so I chase up the GP and get the forms, simple, easy.* (Workwise Employment Consultant)

In addition to providing information, the employment consultant asked questions to deepen their understanding of the services that Work and Income offer, such as allowances to assist clients in looking for work or how to apply for funding to start a business when a client is on an Invalid's Benefit. In one case the employment consultant was able to use this information to help a client access a clothing grant the day before an interview. The employment consultant also shares job vacancy information with a local Work and Income work broker when none of the clients on their caseload were suitable for the role. The same office invited the employment consultant to attend a seminar by local training institutions in order to become more familiar with educational opportunities offered in the area. The consultant enjoyed the opportunity to further develop relationships with case mangers working at that branch.

The GPs, Work and Income and Workwise front line staff have all been flexible in order to address the challenges associated with delivering different services together. The local Work and Income branch offered Workwise temporary use of their meeting room until renovations at general practice Site A were complete.

> *Some of the clients didn't feel comfortable going to a Work and Income office to see the EC, especially if it was an early appointment, some people refused to meet the EC there. I expressed that to the lead GP at Site A and he has tried to alleviate that by giving us more support [a room one morning per week]. It's a compromise and we do understand the restriction he has on the building and we do appreciate that he's making an effort to invite us in.* (Workwise staff member)

The Regional Health Advisor and the Workwise team leader or employment consultant maintained both a frontline and operational relationship. In addition to discussing referral processes as outlined below, at times they would discuss issues relating to individual clients. In one instance the team leader and RHA worked together to mediate and address a serious incident that occurred between a Workwise client and a local case manager.

> *One particular example, but it was a one off, the attitude of the case manager as I explained earlier [an incident where there 'was almost a complaint to Work and Income about being called insane'] and really just a misunderstanding and trying to clear that before it became any more serious. That level of discussion was with the RHA and me. Everything was smoothed over—it could have potentially become an issue and it didn't.* (Workwise staff member)

All interviewees valued the operational communication as an important feature of the partnership. Communication involved discussing and troubleshooting the cohort trial referral processes, regular updates relating to the cohort trial, and sharing relevant information, though there were no formal inter-organisational reporting mechanisms at the strategic level.

Early communication at the organisational level involved development and regular review of a written process to ensure referrals to the cohort trial were well coordinated through a central point at each organisation. A number of the Workwise clients referred to the cohort trial were ineligible, falling outside the age range or not meeting the benefit criteria, although most were in receipt of benefits. Work and Income wanted to assist those clients so a referral process for local case managers to follow up was developed. Case managers, who may not be

aware of the cohort trial with Workwise, were asked to make contact with the client, have an employment conversation with them, and offer any appropriate support.

> *We could see that that might enhance the project a little further, we just didn't want to leave those people [ineligible for the cohort trial] just sitting there.* (Work and Income staff member)

Work and Income and GPs

As demonstrated through the relationship survey (see Appendix C), although Work and Income employees and General Practitioners (GPs) recognised the importance of each other's role in assisting a client, communication between them was limited. Interviewees indicated that most of the communication related to clarifying information on medical certificates, such as reassessment or issue dates. GPs did not appear to be familiar with the organisations' rebranding, referring to Work and Income as WINZ in both the survey and at interviews. Most Work and Income case managers and work brokers did not regularly contact general practices. A few occasionally contacted practice nurses via phone calls or fax as they reported they were usually more available than the GP. Most of the Work and Income employees had never been approached by the GP.

Rather than sending a client back to the GP for more information or to clarify the medical certificate, most case managers chose to utilise the RHA. Contact between case managers and the RHA occurred regularly, ranging from every day to once a month. The contact usually happened through face-to-face conversations if the RHA regularly visited the branch, or through email or phone. The purpose of the contact with the RHA was to:

- ask for professional advice on a client's capability to work
- ask questions about medical certificates
- ask questions about conflicting information
- clarify eligibility for the Sickness or Invalid's Benefit
- ask about types of treatment available
- ask for help to translate medical terminology
- ask the RHA to contact the client's GP.

This system was advantageous because the RHA was one point of contact for all medical issues, having the expertise needed to make decisions around capability to work and benefit eligibility. Additionally the RHA could quickly turn around the information, usually replying within 24-48 hours. One interviewee described the RHA as the "glue" between Work and Income and the GPs because they facilitated communication through their understanding of the work of both parties.

> *I'm no doctor so I don't know if they [clients] actually qualify. Some of them come in with unpronounceable conditions so it's best that I put that through to the professionals to just make sure, is that an issue? Is it not? Is it a passing thing? Is it terminal? I just don't know so it's best to get clarity from them and just go with what they recommend.* (Work and Income staff member)

The RHA reported they had a good relationship with GPs. Using their medical expertise, knowledge about clients and knowledge of the Work and Income processes, they talked with GPs on the phone or occasionally by e-mail. The RHA reported that GPs sometimes rang during a client's appointment to discuss specifics about benefit entitlement or Work and Income's decision making processes. The RHA believed that being a health

professional made communication easier and often used the opportunity to educate GPs about their obligations regarding the medical certificate.

> *…I can talk to the doctors about where we're at with things and just encourage them to be more aware of a person's capacity to work. When I talked to the doctor yesterday about the person with the headache and the depression, they absolutely understood what the situation was in terms of this 24 year old with tension headaches, migraines and depression diagnosed but not treated and where that sat that 24 year old in terms of being on an Invalid's Benefit. The doctor realised that [was] not a good place, though they had indicated clearly towards Work and Income that this person could not work. Yet the doctor didn't really have very much information, the client doesn't see [the doctor] very often. So that educated that doctor on what their real responsibilities are in terms of providing a medical certificate.* (Regional Health Advisor)

Although the RHA's interaction with many GPs was positive, they noted that relationships could still be challenging due to logistical issues, such as GP's availability, and responding to Work and Income queries could be seen as unfunded extra work. Gaps in the work process between Work of Income and the GPs which related to one-sided communication or the lack of communication methods was also seen as a challenge. They noted that a health professional could not intervene on behalf of a client "to get their money back" unless they had been given clear authority to perform an advocacy role by the client. Work and Income does not have the logistics in place to respond to inquiries from GPs in relation to their client's benefit entitlement or their benefit status, which could have an impact on vulnerable clients.

> *A health professional sends a letter to Work and Income and they expect responses. If you send a referral in health, you get a response, but Work and Income doesn't respond to those. The only way an external person will get a response from Work and Income is with consent from the client and also if that person is an agent for the person or a Work and Income business. That's quite a difficult thing for health to understand. I can understand the logistics of the situation but it does leave a big yawning gap for vulnerable people.* (Regional Health Advisor)

The impact of the gaps in Work and Income processes were reflected in the frustrated comments of the two general practitioners interviewed. They stated they never received any written feedback letters, even if they indicated on the medical certificate that they wished to be contacted about the patient. In the absence of information from Work and Income, they had to make decisions solely on information that came from the patient.

> *Dealing with WINZ is just a nightmare. They have privacy issues which means that they never ever, ever, ever speak to us and so the only way you can actually tell what's going on with WINZ is actually what the patient tells you. The patient will sometimes say, "oh yes WINZ has organised a something for me, some training but, oh, damn it, wouldn't you know it, but it was the day that I was blah, blah" …It's just hopeless.* (GP2 Site A)

Additionally the GPs questioned whether or not it was their role to provide the type of information that Work and Income required from them. They felt they were able to provide general information about a patient's medical condition; however, as they were not experts in occupational medicine, they struggled to identify a client's work capacity.

I think in an ideal world we write the medical problem of the patient and we give it to WINZ and they could have an occupational medicine person working out what the person can do and when because that requires a little bit of understanding in occupational medicine. Our job I think is to present a medical report but we're doing a lot more than that. We try encouraging the patient to go back to work and negotiating with them how long they're going to be on the Sickness Benefit. Also the patient might be saying well, "I used to work as a builder but I can't do that with this condition" and it's sometimes a bit difficult, it's a grey area. (GP1 Site A)

However, the GPs did note they felt Workwise was able to help them bridge this gap and act as occupational medical experts, particularly for the more complex patients experiencing mental health issues.

That's why it's good to have [Workwise]. I said an occupational medical expert but that's essentially the role that they are filling. (GP1 Site A)

One interviewee noted that as the welfare changes were rolling out, Work and Income branches may wish to have more visits from the RHA to facilitate internal and external communication.The area operations manager noted the Health and Disability Coordinator would typically liaise with local GPs and nurses to provide education and information. However, this role had been vacant in the Wellington region since February 2013, possibly causing some gaps in communication with local practices and Compass Health PHO.

Workwise and GPs

Workwise took responsibility for developing their relationship with the general practices, regularly communicating with the GPs at both the frontline and operational levels. Communication occurred through a variety of mechanisms, including e-mail, phone, fax, text and face-to-face meetings or client appointments. Additionally, the employment consultant took advantage of being co-located at the practices to catch GPs in the hallway or lunchroom and give a quick update or signal a need for a more in-depth discussion regarding a patient's needs.

The employment consultant understood the GPs have individual preferences around information sharing and therefore it was important to understand those preferences. In response the employment consultant adapted the electronic progress note form to brief hard copy progress notes left for GPs, continuing to e-mail those who preferred it. On occasion the employment consultant facilitated clients' paperwork for the doctor, such as completing a psychological profile so a client could be referred to counselling as requested. The employment consultant identified they and the GPs would talk to a client jointly at an appointment if there was a need.

One [meeting with the GP] was about being referred to counselling, the client had asked me. Sometimes the clients don't want to think about the money it's going to cost for another [GP] appointment, so if they mention something I can say, "oh look, I can tell the GP and that saves them $25.00." I'm there looking after the GPs client and it makes sense that we sometimes share information that's crucial to this person's health. (Workwise Employment Consultant)

The GPs also felt that on-going communication about individual patients was an important part of their relationship with Workwise.

I think it is important for them to keep on telling us how they're getting along with particular people because then we can actually bring that up in conversation with the patient and see how people are doing… from time to time. So for Workwise to say, "we'd really like to have a chat to you about it". They were doing quite nicely but [it dropped off] in the chaos of the renovations. (GP1 Site A)

The primary operational relationship between Workwise and the practices is between the team leader and the lead GP at each practice. This relationship extends to the employment consultant and links to the other GPs at the practice. The Workwise team leader communicates with the GPs at least fortnightly and has been able to address challenges, such as initially low referral volumes from Site B and the renovations at Site A.

Communication has been really important to maintain because of the integration that we would like to have and the GPs have expressed the same feeling—especially since the presentation—that they benefit from having the employment consultant based at the practice. The lead GP made a big effort to communicate that to me. (Workwise staff member)

Workwise operational staff noted they were plugging a gap that the GPs were eager to fill, which made the establishment process smoother, with less need to obtain "buy-in" prior to implementation.

Critically both GPs that came on board wanted to be on board. They just said, "great let's do it and we'll find the space and we'll do it". There was actually very little need to change people's minds or introduce something—it may have been a new topic but they were straight on board so that means that your energy goes straight into quite quickly operations, rather than educational and rollout. (Workwise staff member)

Challenges

Generally respondents felt the programme had experienced some challenges due to personnel changes at the strategic and operational levels, including leadership changes with the Compass Health Chief Executive and Workwise' operational manager. An additional personnel challenge was related to the vacancies in the employment consultant role. However, none of the stakeholders identified any frontline or delivery issues related to that personnel change, possibly because the Workwise area team leader carried on the role herself. On a practical level, the general busyness of the GPs and the renovations at Site A were identified as a challenge to achieving integration, but had been overcome through perseverance and goodwill.

> *Building the level of integration has been quite hard work actually from our end. I think it's been hugely successful but only due to the level of the hard work by the EC, by the team leader involved and taking that time and really chasing people, by persevering. Of course the nature of the setting, the people are very, very time poor so it's an obvious one but for me it's the overriding one—it takes the most time and the most effort for all involved and the most goodwill from all parties to get through.* (Workwise staff member)

The business nature of GP practices, and the fact that employment support is not typically provided through PHO funding mechanisms as a "package of care" created challenges around funding for room rent.

> *The GP surgeries are for profit so there was some initial talking again about how rooms would be resourced and who would pay for that. We've tried to work with the PHO to be an active partner in terms of some of the contribution of costs.* (Workwise staff member)

Privacy and consent

Interviewees from all organisations identified that privacy and consent limited the direction that information could flow and was likely to impact on communication and the potential for closer relationships to form. Work and Income interviewees identified they were restricted on the type and amount of information they could share with Workwise, which may limit both organisations' ability to provide support to clients.

> *There are privacy constraints around all of this. The employment consultant might get consent from the client to provide us with that information and that's fine, but until we actually make contact with them [the client] and get that consent we can't feed anything back so that's a bit limiting.* (Work and Income staff member)

Privacy and consent issues also governed Work and Income's relationship with GPs. As part of establishing a client's entitlement, Work and Income receives consent to clarify any information given to the agency, such as whether or not a client is being treated for a health issue listed on their medical certificate. However, in order to ask a GP about a client's particular experience of the issue, such as how a prescribed medication impacts on a client's daily life, Work and Income must obtain additional consent from the client.

> *When a person applies for a benefit there are certain things that they sign in their obligations. Work and Income are entitled to seek clarification of information that the client provides to us, so any information on the medical certificate, we can clarify, but that's all we can do. If we want to do more than that, we actually need to have particular consent from the client. For that person I was talking about with the headaches etc., I would just be establishing what it means in terms of medication because [the doctor] is*

indicating that this person is not working. I can contextualize it and ask the question but I wouldn't go any further than that. (Work & Income representative)

Privacy and consent conversations occur regularly as part of Workwise' services. As they seek to help a client manage relationships across health and welfare agencies, as well as employers and families, the organisation needs to assist clients to decide what and how much information they want to share.

Our conversations for individuals around what information they want to share—with every employer people may choose to disclose or share different bits of information, just as we do with different people that we meet so it's no different, and that's where a consultant would guide and advise someone. If the client doesn't give us permission to talk to an employer because they don't want to disclose that also limits what we can undertake on that individual's behalf. (Workwise staff member)

However, the employment consultant believed that privacy and consent issues were a barrier to sharing some information and that if these were able to be addressed, the relationships between local Work and Income case managers and the employment consultant could develop further.

There is one thing [that's a challenge] and that's the privacy and consent. Now I've become an advocate for one client, but normally you cannot discuss clients with each other [Work and Income] and sometimes it might be useful. Going forward, that might be useful if that could change in the future, having more of a relationship with them where you can discuss clients if need be, like if [the proposed action] is detrimental to their health. Whatever we can discuss what we're kind of [discussing] presently. (Workwise Employment Consultant)

A Workwise representative noted the differences in how Work and Income and the health sector manage consent and information requirements. When examining Work and Income's consent processes, the potential consequences or sanctions of not providing consent were more apparent than in health.

From a GP and a health perspective, consent is managed in a different way from Work and Income. If you don't share that information [with Work and Income] you won't get or you may not be entitled to claim a benefit in the same way, because there is an obligation that you provide the information. It's still consent and you can choose to or not but there's a consequence whether you consent or not which is quite different about the sharing of information [compared to a health agency]. (Workwise staff member)

Interestingly, one of the GPs commented that the issues around health information privacy and consent and the apparent limitations that the law applies to communication may be misunderstood and not applied correctly.

I don't know if that [privacy and consent] issue is actually legitimate either, I think if both parties are acting in a genuine interest of the patient, I think you're allowed to share information, I think sometimes people cite the privacy act when it's not really appropriate (GP1 Site A)

Outcomes and learnings

All of the interviewees involved with the programme identified a number of positive outcomes and learnings as the establishment phase of the programme came to an end. Interviewees discussed clarifying and developing organisational roles and relationships, the changes that had occurred at frontline delivery and the value of the partnership. Interviewees also identified suggestions for improvement and the future direction of the programme.

Many interviewees believed the changes for individuals involved in the employment programme were the most significant outcomes so far. The service was seen to fill a gap in support for those individuals who have mental health issues and need help to stay at or return to work. They believed that most of the clients experienced health improvements in a short space of time. One GP shared how the prospect of employment helped one patient stabilise his epilepsy and another address his anger management issues.

> *I have two patients who have returned to work which was really good, they picked up one who had an anger management issue. They actually both had epilepsy and it was a matter of stabilising the epilepsy a wee bit more and I think the prospect of getting back to work actually made them do that. One of them …was actually more of an anger management thing, [the patient] was just relying on his epilepsy to say, "I can't work" but he's back at work.* (GP1 Site A)

The employment consultant stated that the GPs noticed changes in their patients' moods and behaviours.

> *When they [the GPs] walk down the hallway and go, "oh, I saw such and such the other day, and he actually looked at me and smiled, he didn't look at the floor!" Things like that make it all worthwhile.* (Workwise staff member)

One interviewee identified the programme highlighted why it is important to talk to individuals about their employment early, in order to offer them support as quickly as possible.

> *I think that's a really powerful affirmation of what value this offers and why it is important that people get to have employment conversations as soon as possible around whatever point of recovery they're in, but also whatever point of employment they're in because someone who risks losing their job, to someone who's looking to re-enter, it's really important that that support is offered as quickly as possible.* (Workwise staff member)

Some interviewees highlighted they now have a better understanding of the barriers clients experience and that bringing the agencies together enabled them to facilitate the connections and make it easier for the individuals in the programme.

> *Bringing the agencies together to support the person—not having the person going to multiple agencies and get bits without any real connection. I think all the partners are positive to do that because without that intent, it doesn't matter what we do. The cogs between those government agencies will turn whether we're oiling them or not, so it's nice to make it smoother and for the individual that has to pass through.* (Workwise staff member)

From an operational perspective, other than keeping the referral criteria wide, the interviewees did not believe there were significant differences when working with primary care or secondary care, or with the two Wellington practices compared to the Hamilton practices. Staff noted it was important to take the time to develop individual relationships and understand how the practice is run before expecting the initiative to produce results.

> *In terms of the delivery and set up it's …about building the momentum across all of the practitioners within that service, which is no different to a clinical team. You'll get your "I'll wait and see if it works" and "that's great, that's new, let's do it" kind of people and so that's no different within the GP practices when you've got a range of practitioners.* (Workwise staff member)

Establishing roles and relationships

All of the operational partners felt the relationships developed as a part of the programme were very valuable. One Workwise representative noted the relationships with the GPs had developed from a "standing start" leading to the achievement of integration at each practice. Respondents noted that regular contact and communication, open dialogue and good awareness of the organisations were keys to establishing relationships.

> *The relationships that I've developed are improved on as you have more contact. As contact is increasing, you get to understand each other more and you get more respect and appreciation of how we work and how we can integrate and how we can support each other.* (Workwise staff member)

They also said it was important to have a key contact and clear communication throughout the development of the relationship.

> *I think that's the key: having a key contact and clear communication. Whatever the changes are and whatever the issues and challenges are going to be, being able to discuss and communicate at an operational level and at a higher level are vital. Keeping those channels open would be really important for the support of the client and for the support of Work and Income. I'd say it's a two way process.* (Workwise staff member)

The relationship between Work and Income and Workwise was seen as very valuable, as their organisational experiences complemented each other and offered better support to the clients in each service, by drawing on the expertise of the other organisation.

> *As an organisation we're quite good at building the plane in the air so we just need to get in there and learn from the different things that we implement. We can be quite innovative but it's quite nice also that there's organisations that already exist that can partner with us so we don't have to shoulder the full responsibility of doing that all the time. I think it's sending quite a clear signal that we don't have to be everything to everybody and that where there is expertise we can tap into that actually and work more as a partner rather than try to do it all ourselves.* (Work and Income staff member)

Work and Income indicated they appreciated Workwise' role as an expert able to work with clients facing multiple barriers to returning to employment, whereas Work and Income was used to working with clients who had fewer or less complex challenges.

It [the partnership] has to be a good thing. We can see from our information about clients that turned up in this cohort that they may be quite difficult people to work with, which is good in terms of Workwise' skills because if you are used to working with less complex people which is what our internal expertise is, it's very difficult to work with the more complex people. We're building our expertise, but Workwise have got the expertise and they can work with the complex cases so they've probably been working with the right people. I think that the research shows, Work and Income needs to have this service. (Work and Income staff member)

The value of these relationships at the frontline level was also apparent, reflecting the organisational goals of partnering together to better assist clients.

Great relationships and that's how it should be, because we're both working together to help that same client. It's wonderful and I think if it could be like that everywhere then gosh, if we're successful we could help a lot of people. It makes their [Work and Income's] life easier, our lives easier and the client's life easier. (Workwise staff member)

Frontline organisational changes

Interviewees noted that both the GPs and Work and Income experienced some organisational changes as a result of working in the partnership. Work and Income had been a flexible and responsive partner, as demonstrated by their willingness to make changes in their organisational processes. One change was on the medical certificates, allowing and encouraging GPs to include a patient's enrolment with Workwise as a type of "treatment and/or support". Additionally, Work and Income representatives said frontline conversations between their case managers and clients were changing as a result of learning from Workwise.

From a frontline perspective, even though somebody has got a disability that we think is a barrier to work, that actually if this person has had that conversation with their GP and their GP has ascertained that they're willing and able to work, it's made it a bit real for us. Rather than a change in policy being driven down and communicated out to front line, I think this particular project has highlighted that these are real conversations and they are already occurring. That actually the change that we're implementing through welfare reform is in line with what's already happening. The conversations that we have with the [Workwise] employment consultants at a front line level makes it real for our case managers—they can kind of see the conversations that are happening and emulate that. (Work and Income staff member)

Workwise representatives believed that having an employment consultant in the practices would continue to demonstrate the links between the social determinants of health to the GPs involved in the programme, as well as GPs as a group.

I think there's a shift in awareness of the importance of having an employment consultant and what that can mean for the social determinants of health, and how it can actually support that wellness and recovery. I think that's an on-going learning for GPs because obviously it's not just one person, you're trying to influence a number of people. (Workwise staff member)

Value of the partnership

All of the interviewees involved in the programme believed that the partnership was valuable. Work and Income believed that the upcoming welfare changes would be a challenge, but the partnership allowed them to learn more about how to have employment conversations with all their clients.

> *We have to make those changes, we've got to make this work and there's no reason why it can't work and everyone can see the value of it. We've been hearing for a long, long time that work is a health intervention and that obviously everybody is aware of the benefits and so regardless of what benefit type and what barriers, having that work related conversation is really valuable.* (Work and Income staff member)

They noted the partnership helped them think about other areas outside of the demonstration programme where Work and Income and Workwise could partner.

> *We've identified other ways that we think we might be able to work together [with Workwise], outside of this project and that may or may not have happened on its own course anyway but …linking with Workwise early on has been helpful.* (Work and Income staff member)

Generally there was a sense of achievement and momentum among interviewees, with hope that the partnerships would continue through this programme and possibly expand to other sites.

> *A key achievement is saying, "Well it can be done". You do it once, you can only think, "oh well that worked but maybe it's good luck", and so it is an achievement to be able to roll out in two other sites and see it working.* (Workwise staff member)

Suggestions for improvement and next steps

Interviewees believed that the programme was well established and would be moving into a consolidated delivery phase where relationships and processes would develop further. Both frontline and operational staff had suggestions for improvement and the operational staff shared their vision for moving the programme into this next phase.

Communication and resources

Work and Income frontline staff identified a need for increased knowledge of local agencies, as well as the services the agency provided. They wanted better resources, such as free part-time training, for clients who had been on the Sickness Benefit and were unable to attend full-time courses or pay for private part-time polytech courses. One case manager indicated they preferred to learn about the agency face-to-face rather than through e-mails or other advertising.

> *We need to know more about what agencies are available in [the local] community because we can't be dealing outside [this area]; we have to focus on this particular area. What is here for our clients? How are they going to help clients? Is it a treatment thing? Is it an employment thing? Is it what the GPs recommend? Is it about mental health, people dealing with mental health going to this specific agency? Do they specifically deal with this problem? There's so much information we could do with.* (Work and Income staff member)

Although only a few Work and Income case managers had been involved with the programme, they noted on-going feedback from external employment agencies was very important to ensure they could avoid duplication and work together to support clients, as they may have access to resources that the agency did not. Several of the case managers thought an employment plan template that contained contact details for the employment consultant and a list of the client's activities and interests would be a useful way to communicate.

> *Communicate it to the site so that we know what they're [employment agency] all about. Even having an employment planning template so that when they come in to us they just give us that sheet and we're like, "oh yeah, you've indicated that you want to go into admin; you've looked into Whitirea courses" so that we know where they're at. There may be courses that we can offer them that Workwise don't know about, maybe opening that communication gate or door a bit better.* (Work and Income staff member)

Workwise interviewees focused on promoting on-going communication with the other partners at the frontline. The Workwise employment consultant echoed the desire for ongoing communication from Work and Income case managers. It was very important for the employment consultant to know of any issues arising with clients as soon as possible. With the GPs, Workwise wanted to continue to improve relationships and communication, GPs' understanding of the referral criteria, and overall appropriateness of referrals.

Sustainability

Workwise and Work and Income were both interested in asking questions around sustainability as the programme moved into a consolidated delivery phase. One interviewee stated this was an opportune time to formalise reporting and begin having regular steering group meetings. Workwise operational staff hoped the

steering group would be a forum to give each partner a chance to voice any issues or concerns, such as room rental, clarify each organisation's desire for the programme moving forward, and offer new opportunities.

One aspect of sustainability involved discussing the PHO's role at a strategic level in providing employment services within primary care.

> *The bigger picture work that we're doing in the primary care area, to identify how this work can be paid for longer term is then going to feed back in and inform those discussions. When you can sit there with the PHO around the table saying, "great there's two GP surgeries that we can currently work at, what about the other twelve that want to?" and there's no easy answer to that until we bring back in the big picture, how will it be paid for one day so that work can continue and it then has to inform those regional, strategic relationships.* (Workwise staff member)

Workwise representatives hoped that the steering group for this programme could provide a forum to help develop relationships between health and welfare agencies, which could begin to address the wider challenges facing the sectors.

> *Some of the added value of the combined steering group is bringing health and welfare to the same table because at the end of the day it's all the same people that we're working with. At times those organisations don't have the ability to connect and again, some of the work that we [Workwise] do is connecting the health and welfare and the health and employment spheres.* (Workwise staff member)

Workwise noted that to be sustainable, employment support programmes would need to find solutions to address the differing organisational focuses between health and welfare. This was demonstrated through the differing referral needs—GPs need to have as few criteria as possible, but Work and Income focuses on long-term beneficiaries.

> *Longer term, as we see programs evolve, we need to be able to meet zero exclusion and work ability because we know that's what's going to work from a GPs' point of view with referring in and […] being able to ensure targeted support is provided for people who are a higher risk of becoming long-term benefit dependents. So there's going to be a funding gap in and around that which is a wider population health issue, sitting alongside a welfare issue—I think that's an interesting space that we will all move into in the future.* (Workwise staff member)

Discussion

This evaluation shows that through communication and coordination in the partnership, the demonstration programme began to address the system barriers which hinder individuals experiencing mental health issues from returning to employment. Workwise was the primary driver for the partnership at all levels. By bridging the communication gaps between the clients and Work and Income, the Workwise employment consultant assisted and supported clients to navigate Work and Income's system. The Workwise employment consultant also assisted the GPs and Work and Income's communication, addressing information sharing gaps.

Organisational roles in employment support pathways

Through the analysis of key stakeholder and client interview data it is apparent that organisational roles and relationships within employment support pathways differ between the standard pathway and the integrated employment support pathway created during this demonstration partnership. This was reflected in the type and frequency of communication between key individuals, organisations' alignment and the time it took for the individual to move through the employment support pathway.

Standard pathway

The standard pathway to access employment support is complex and can be overwhelming for individuals with mental health issues. Work and Income employees have generally expected clients to be well before accessing employment support, which can be difficult for people with fluctuating mental health issues. The system is complex and frontline staff can be discriminatory, which increases the challenges for individuals experiencing low motivation and confidence and struggling with disorganisation. These factors often resulted in increased anxiety, frustration and fears. Clients' frustrations were echoed by all the partners, who recognised that communication and system structures often act as a barrier to providing timely assistance.

As demonstrated by Figure 10, in the standard pathway the GP's role is to complete a medical certificate identifying an individual's health issues and their work capacity. Individuals then take the certificate to Work and Income where they are assessed by a case manager. As represented by the solid arrows, if the case manager needs clarification on the medical certificate, they typically ask the RHA to contact the individual's GP. The client may stay in the general case manger pool or may be assigned to a focused case manager. Once Work and Income has received all of the required information from the individual and GP, they assess and grant a person's entitlement. As shown by the circle, after the individual's finances and primary health issues have been addressed, their case manager may ask them about their employment needs, often referring them to a Work and Income work broker or external employment agency to provide employment support.

The communication pathways from the employment agency to Work and Income are represented by dotted lines, as the case managers indicated that communication from the employment agency was limited and sometimes occurred via the programme coordinator. Internal communication within Work and Income appeared to be bi-directional, as demonstrated by the double-sided arrows. The two single arrows demonstrate that communication between Work and Income and GPs was limited to the exchange of discrete pieces of

information, such as correcting missing or inaccurate information on the medical certificate. The boxes represent the primary reason for communication or contact between individuals/organisations within the employment support pathway.

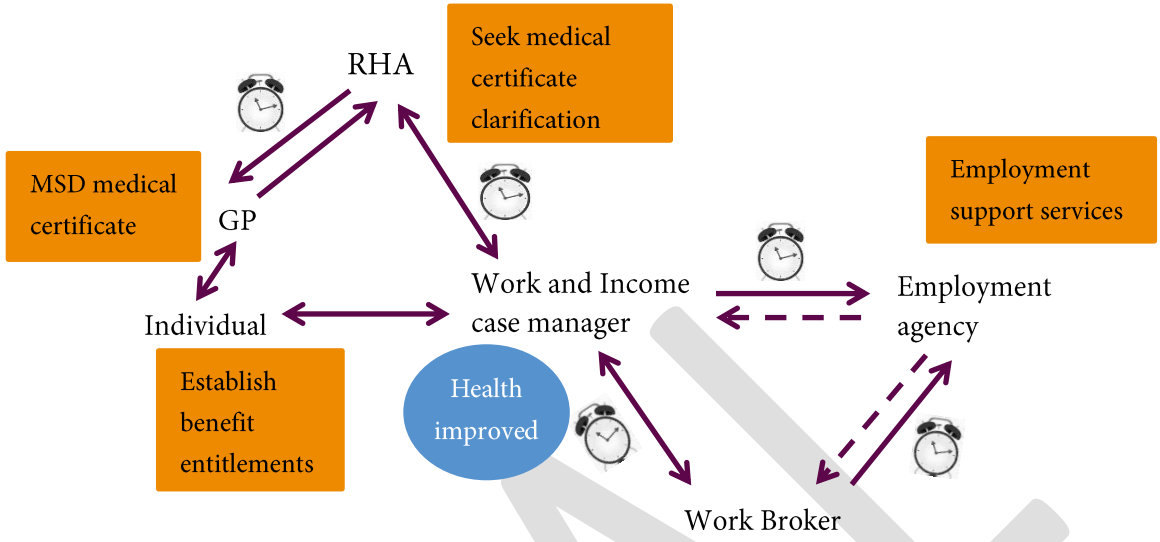

Figure 10: Standard pathway to access employment support services

The complexity of this pathway increases the likelihood that 'at risk' individuals, such as those experiencing mental health issues, will struggle to access employment support services. The limited opportunities for inter-organisation communication increase the chance of delays and information loss. These potential delays, information loss and lack of communication likely contribute to individual's frustrations and feelings of being "passed around". Additionally, the lack of communication between the agency providing employment support services and the individual's GP may mean that potential impacts of a recommended job on an individual's health and vice-versa are not well understood. Clients who are too frustrated or afraid to engage with Work and Income struggle to access benefit entitlements and employment support through the standard pathway. This may be a contributing factor to the fact that people with mental health issues remain the largest group of existing beneficiaries.

The relationship survey and interview results, as illustrated in this pathway, give insight into the mutual frustration experienced by GPs and Work and Income case managers. When GPs included detailed information on the medical certificate and ticked the "please contact me" box, GPs expected they would receive information and communication in response, as they would after referring a patient to a specialist for further treatment. However, when communication from Work and Income did occur, it was limited to clarification around the medical details and treatment of a client's diagnosis, missing or incorrect information, rather than a conversation about how a client could be mutually supported to manage their health issues and address their barriers to employment. It was clear that having the RHA a health professional within Work and Income, take a central role in most of this communication was positive for case managers and reduced the risk of duplicating communication with the GPs. However, as responding GPs did not know who to contact within Work and Income to troubleshoot a patient's benefit issues or ask questions, this role and the Health and Disability Advisor needs to be better promoted. Developing and promoting clear communication pathways, such as a

dedicated helpline or e-mail services for health professionals, would likely reduce delays and information loss, further addressing the system barriers for clients with mental health issues seeking employment.

Integrated pathway

The organisational roles of each partner differed in the integrated pathway. As demonstrated by Figure 11 GPs' had an employment conversation with the patient about their employment goals and then referred them directly to Workwise. Individuals then quickly accessed Workwise support, typically at the familiar location of the GP office. Workwise provided employment support to the individual and served as a bridge between the client and Work and Income. They provided benefit counselling and supported clients to navigate Work and Income's systems to apply for entitlements and other financial support. When compared to the standard employment support pathway, individuals accessed employment support faster.

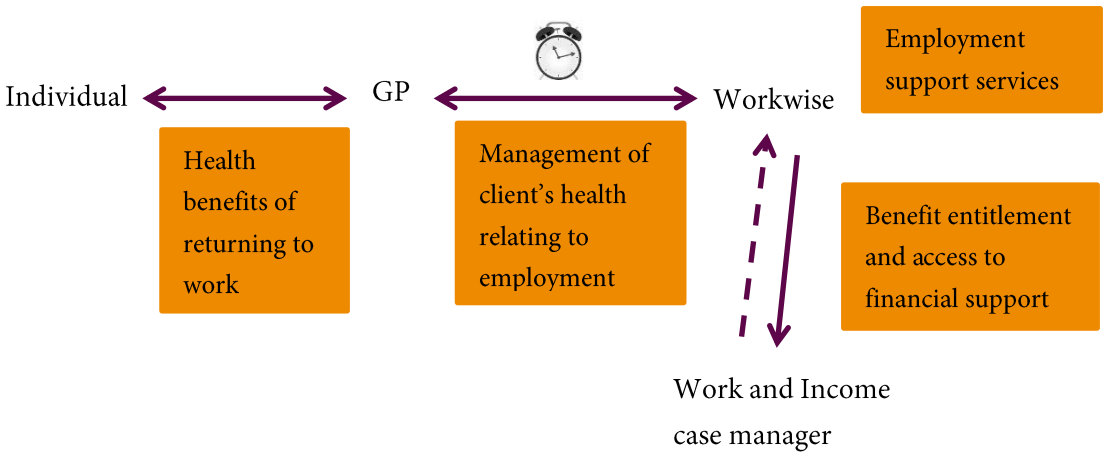

Figure 11: Integrated pathway to access employment support services

Workwise was the primary driver to this pathway, facilitating inter-organisational communication and relationship development. Through regular communication and co-location, Workwise developed relationships with the GPs involved in the partnership. They also facilitated communication between Work and Income case managers and the GPs, reducing the risk of delays or information loss that could occur in the standard pathway, where the RHA facilitated most of this communication.

Communication between Workwise and Work and Income is represented by two arrows to demonstrate that information sharing is occurring, but at the current time Workwise was responsible for initiating most of the communication. Direct communication from Work and Income case managers was typically requests for client information, such as driver licence details, rather than conversations about how the services might coordinate to support a client's employment needs and goals. Additionally, clients were often responsible for informing Work and Income of their involvement with Workwise, as unlike in the standard pathway the referral mechanism was external to the agency. The integrated pathway is a reflection of relationship development at the frontline level. Although communication and information sharing between local Work and Income case managers and Workwise was still developing, the use of Work and Income's meeting room is likely to facilitate this development.

As shown in this integrated pathway, Workwise provides a specialist service to patients experiencing complex barriers to employment, by being co-located with the client's health professional and able to provide more intensive support. Through their role in mediating the clients' relationship with Work and Income they are able to address clients' fear of losing their benefits, a key barrier to pursuing and obtaining employment (Bond, 2011; Drake et al., 2012; Miller, 2006). When Work and Income case managers knew that a client was enrolled with Workwise, they were able to contact and utilise the employment consultant to follow up issues such as missing information with both clients and GPs, reducing delays and frustrations. Having a specialist agency providing employment support also allowed Work and Income case managers to focus on the client's other financial and support needs.

The benefits of the integrated pathway are in line with the fidelity principles outlined in the programme background. Co-location and integration of the employment consultant at the general practices facilitated communication and allowed them to coordinate with the GPs to address clients' health needs related to employment. The directness of the pathway leads to a rapid job search, reducing the period of time that a client is out of the labour market and the coordination with welfare agencies helps clients address their financial needs.

Frontline staff at Work and Income and Workwise should consider ways to share information and further coordinate their services, such as creating an employment plan template that contains both employment agency contact details and client-specific information. Such a template would be client-owned and shared and thus mitigate the privacy and consent issues raised by Work and Income. However, as some clients who experience disorganisation as a part of their mental health issues may find it challenging to keep track of a piece of paper, other methods of sharing this information, e.g. through e-mail or other electronic communication, may also be needed. As programme delivery continues identification and implementation of processes to reduce assessment duplication both within Work and Income and between Work and Income and other employment agencies will be useful and is likely to reduce client stress and fear around engaging with Work and Income.

Client experiences with employment support pathways

Many individuals with mental health issues struggle with low confidence and motivation. They may find it difficult to get organised or to stay focused (Lexén, Hofgren, & Bejerholm, 2012). They may not be able to complete requested tasks or may overlook important requests for information (Lexén et al., 2012). Negative attitudes from frontline staff or employment agencies and a lack of understanding of the client's needs and desires may be anxiety-provoking and are likely to decrease an individual's confidence and motivation (Blank, Harries, & Reynolds, 2011). When these issues are examined in the context of the standard pathway, it is unsurprising that individuals with mental health issues and other complex barriers to employment struggle to navigate the system, heightening their levels of frustration, fear and resulting in a lack of hope and low return to work rates.

The examination of the integrated pathway demonstrates how these system factors are mitigated. Access to intense, individualised employment support in a health care setting resulted in increased confidence, motivation and hope for these individuals. The employment consultant had the skills and time to help clients address their fears and frustrations, as well as their employment barriers such as disorganisation, low motivation and a lack of

hope. Direct communication and coordination with individuals' GPs and Work and Income helped to bridge gaps between the organisations, so clients' needs could be met more quickly. As a result of being involved in the programme, clients felt their health had improved and that someone finally believed they could succeed and achieve their goals.

The standard pathway is also underpinned by the view that people need to get better first and then return to work, as demonstrated by the comments from several Work and Income staff members. In contrast as demonstrated by GPs referral of patients 'quite a depressive state', the integrated employment support pathway allows individuals to access employment support and clinical treatment at the same time. This pathway allows the GPs to provide tailored clinical treatment able to address barriers that the patient and employment consultant encountered as they started the job search process or once the person was employed.

Operational and strategic roles

The role of the strategic staff in this programme was to establish the partnership between Compass Health PHO and Workwise, extending it to include Work and Income. This type of inter-sector partnership, when combined with co-location, simplifies effective communication and enables health providers to offer holistic care through employment support, improving service user outcomes (Browne, Stephenson, Wright, & Waghorn, 2009; Gannon-Learly, Baines, & Wilson, 2008; Porteous & Waghorn, 2007). After the initial establishment, strategic staff reduced their involvement in the programme to an oversight role, providing support to operational and frontline staff as needed. The Workwise CEO regularly shared informal programme updates with the other partners.

Initially, the role of Workwise and Work and Income operational staff was to set up the programme with GPs and create communication pathways between their organisations. As the programme developed, operational staff regularly communicated with each other to troubleshoot challenges and address emerging challenges, such as improving the cohort trial referral processes and increasing the age range criteria. Operational leadership and support of frontline staff have been critical to overall relationship and programme development. The presence of the Workwise employment consultant has benefitted frontline staff at Work and Income, who are now having different and earlier employment conversations with clients. Key stakeholders believed that overall, the partnership improved their understanding of each other's services and specialities, leading to discussions on ways to improve service coordination and potentially extend the partnership to other populations.

Operational staff considered the next steps to embed programme delivery. Workwise operational management were forming a steering group with representatives from each partner, including Work and Income and the lead GPs at each practice. It was hoped that Compass Health, who had limited involvement after the initial establishment, would also attend the steering group. According to the IPS fidelity scale, the purpose of the steering group is to support frontline staff and should meet quarterly or at least every six months while the programme is being established (Becker, Swanson, Bond, & Merrens, 2008). Workwise indicated that the purpose of the steering group was likely to evolve, but the first purpose would be a forum to discuss and troubleshoot any frontline issues, such as the room rent, in order to support frontline delivery. The operational managers noted it would also be an ideal place to begin discussions around the programme's sustainability.

Strong cross-organisational leadership is an important driver of on-going partnership, programme sustainability and growth, and contributes to high-quality implementation of IPS (Dowling, Powell, & Glendinning, 2004; Latimer, 2010).

Conclusions

Due to leadership, communication and flexibility at both frontline and strategic levels, the challenges experienced during the programme have not prevented frontline service delivery, coordination or communication between the organisations. Features of successful partnerships, including the development of clear and defined roles, commitment from all staff, strong leadership and good systems of communication at all levels, were present in this programme (Sloper, 2004). Co-location of the employment consultant within the general practices facilitated relationship development and communication, which is in line with the findings from the Hamilton demonstration and IPS principles (Drake et al., 2012; Te Pou, 2013).

Workwise has been the driver of the partnership and facilitated most of the coordination and communication between the agencies, but the creation of the steering group will offer the opportunity for the other organisations to increase their involvement and further define their roles in the partnership. The key stakeholders involved believed the programme was valuable and that it needed to continue and potentially expand. All of the interviewed clients had more hope, motivation and confidence as a result of participating in the programme, and believed others experiencing similar challenges should have the same opportunity. However, in order for integrated employment support in primary care to be sustainable, partners from each sector will need to collectively address the key issues of privacy and consent, the differences in referral preferences and on-going funding.

Appendices

Appendix A: Evaluation objectives and questions
Appendix B: Evaluation methodology
Appendix C: Relationship survey results
Appendix D: Interview schedules

Appendix A: Evaluation objectives and questions

Table 4: Evaluation objectives and questions

Evaluation Objectives	Evaluation Questions
1. To examine the establishment of the formal and informal roles of each partner involved in the Wellington EBSE demonstration programme.	1a. What are the roles of each partner, including GPs, Workwise consultants, other health professionals and Work and Income, involved in the Wellington EBSE demonstration programme? 1b. How do the relationships between Work and Income and the other partners (including GPs, Workwise consultants and other health professionals) develop over the course of the demonstration programme?
2. To examine how the role of each partner in the EBSE demonstration programme aligns to enable individuals to take steps toward employment.	2a. In what ways do Workwise and Work & Income (including case managers and work brokers) communicate and share resources to inform strategic and operational decision-making processes? i. How do these interactions affect the relationships between the partners? 2b. What are the formal and informal mechanisms by which GPs, Workwise and Work and Income case managers and work brokers identify common clients? 2c. In what ways do Workwise employment consultants and Work & Income (including case managers and work brokers) communicate and share resources to help enable individuals to take steps toward employment, ensure they receive full benefit from each service/support and prevent duplication of services?
3. To understand practice and system characteristics that influence a patient/client's choice to participate in the EBSE service.	3a. For individuals participating in the service, what characteristics, (e.g. client self-efficacy, support networks, smooth referral process) influenced their choice? 3b. For those clients who are invited to participate in the EBSE service but choose not to, or for clients who agree to participate but who then don't engage, what are the reasons for declining? i. Are there particular characteristics or self-reported barriers that identify these people?

Evaluation Objectives	Evaluation Questions
4. To identify and understand the current outcomes for individuals involved in the EBSE service.	4a. What are the early outcomes (e.g. staying engaged in the service, undertaking activities typical of a person seeking employment, employment if applicable) of the individuals enrolled in EBSE services at these practices? 4b. In what ways does an individual's motivation impact on their outcomes (e.g. staying engaged in the service, undertaking activities typical of a person seeking employment, employment if applicable)? 4c. In what ways do the actions of the health professionals involved impact an individual's motivation and outcomes (e.g. staying engaged in the service, undertaking activities typical of a person seeking employment, employment if applicable)? 4d. What have been the changes (if any) in the individuals' relationship with Work and Income? 4e. How could the role of each partner, particularly Work and Income, evolve to best support outcomes for individuals involved in the EBSE service?
5. To examine the ongoing implementation and adaptation of EBSE at the Wellington primary care sites.	5a. What are some of the ongoing effects of co-locating an Employment Consultant in primary care? 5b. How do site characteristics influence these effects? 5c. What setting characteristics, including characteristics of the GP practice, Workwise providers, and the funders, contribute to an 'ideal' implementation of EBSE services in primary care?

Appendix B: Evaluation approach and method

This process evaluation drew on the evaluation and research traditions of theory-based evaluation and utilisation method theory. These approaches are appropriate to the developmental and learning focus of process evaluation and guided the framing of the evaluation questions, as well as methods chosen to collect and analyse the evaluation data. A brief description of each approach and how it shaped the evaluation follows.

Process evaluation

A process evaluation assesses how a programme or intervention is working during the execution of a programme. Process evaluation looks at how the programme is being formed or how its processes are coming together. This information can be used to feed back into the programme, make changes and ensure it is working to best effect. The data collected looks at what happens within the programme, such as the number of people taking part compared to all those who were invited, delays in delivery of a service, the demographics and if the programme was carried out as planned (Brophy, Snooks, & Griffiths, 2008)

Theory-based evaluation

A theory-based evaluation approach (Chen, 1990; Funnell & Rogers, 2011) builds from understanding how the intervention is expected to work. It requires identification and understanding of the activities and mechanisms that are expected to lead or contribute to intended outcomes of an intervention (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. It also helps identify criteria for assessing quality, how well the intervention was designed and delivered and what outcomes occurred and with what impact. It seeks to explore why is a programme working or not working as expected, rather than simply describing whether or not the intended outcomes were achieved. The results of the formative evaluation conducted in Hamilton, and the EBSE principles and fidelity scale provide an existing framework to develop evaluative questions that examine the potential roles of each organisation involved in this demonstration programme.

Development of programme theory is ideally a collaborative process that draws on the views and experiences of key stakeholders. The programme theory was intended to be developed in the steering group; however, as the group did not come together in time, the programme theory relied on partnership literature and the formative evaluation to guide analysis of the partnership processes and role development. The aim of the evaluation was to look at the roles and relationship development with the partners involved in this demonstration programme. Additionally, general IPS principles and the IPS fidelity scale were used to understand how implementation variance could affect the delivery of this employment support service.

Utilisation evaluation methodology

Utilisation focused evaluation (UFE) is an approach based on the principle that evaluation should be judged on usefulness to the intended users (Patton, 2008) UFE is a guiding framework and does not prescribed to any specific content method or theory; it can include a wide variety of methods and paradigms (Ramirez & Brodhead, 2013) UFE facilitates an evaluation and learning process in which evaluation findings are applicable

to the real world and the stakeholders involved in the programme. Those that benefit from the evaluation, or the intended users, are important to the process and must be identified and involved in the decision making process of the evaluation (Patton, 2008; Ramirez & Brodhead, 2013).

This evaluation applied UFE by identifying the partners contributing to the programme and considering how they might benefit from the evaluation. The primary stakeholders, Work and Income and Workwise, provided input and feedback on the evaluation goals and objectives. The findings and conclusions resulting from this evaluation will contribute to improving this programme and future service delivery.

Data analysis methods

The following section describes the data analysis process for the qualitative and quantitative data collected in this evaluation.

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, such as communication, were developed and organised under higher categories to describe the range of enablers and barriers to inter-organisational relationship development.

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 described the interactions between the partners and their understanding of their organisation's role. Client's perspectives and experiences relating to accessing employment support were also identified. Quotes were used to illustrate important results.

Inductive and deductive analysis

Theme development for qualitative data can be done through both deductive and inductive analysis. Deductive analysis develops the thematic codes through consideration of a theory or previous data or research. Inductive analysis utilises raw data to develop thematic codes. Theory driven approaches provide a stable and more reliable starting point for code development; however, data driven approaches are likely to represent the raw data better in the thematic codes and in the final theory or conclusion (Boyatzis, 1998) This evaluation utilised both inductive and deductive analyses to derive thematic codes and determine the findings.

Analysis of quantitative data

The process evaluation undertook limited secondary analysis of the available routine programme and client data for the period of the demonstration programme covered in this report. This evaluation uses descriptive statistics to describe the programme referral rates, client demographics, diagnoses, activities and outcomes. These summary statistics are useful to demonstrate clients' characteristics and activities (Trochim, 2006). An analysis of time that the employment consultant spent delivering employment support services was also conducted to identify and demonstrate the intensive nature of the service.

Summary

This process evaluation utilised programme theory evaluation methodology through consideration of the partnership literature and application of inter-organisational relationship development in the context of delivering employment support in primary care. Given the early stages of programme implementation, the process evaluation was a timely and appropriate approach to clarify the roles of each organisational partner and identify how they could further develop their relationships and grow their partnership roles.

Appendix C: Relationship survey results

Evidence-based supported employment demonstration in Compass Health primary care practices, baseline and follow up survey results

The general practitioner and Work and Income baseline relationship survey was distributed in mid-May 2013 and aimed to briefly examine and present preliminary results about their working relationship. A follow-up survey was conducted three-months later in mid-August[11]. The purpose of repeating the survey was to determine whether any changes in communication or working relationships had occurred.

Work and Income case managers from Porirua Community Link and Newtown Community Link and general practitioners (GPs) from the Newton and Waitangirua practices were invited to participate in a short online survey examining their working relationships and communication. Twenty-four Work and Income case managers from Porirua and eight from Newtown responded (n = 32). Two Newton GPs and three GPs from Waitangirua also responded (n = 5).

The second survey had a lower response rate, with only eight case managers from Work and Income Newtown, two GPs from the Newtown practice and one GP from Waitangirua responding. The survey repeated the same questions on the working relationship and communication and also gave the opportunity for participants to provide feedback on any changes that have occurred since the initial survey. Across all the questions, respondents from different locations, length of time in role and length of time working in the Wellington area responded similarly (see the Appendix for participant characteristics).

Working relationship

Participants were asked how important it is to have a working relationship between doctors and Work and Income when supporting clients or patients. In the baseline survey, most respondents (n=26) indicated that it was important or very important to have a working relationship with the other party. A small number were neutral (n=4) or considered the relationship unimportant (n=2) (Figure 12).

The follow up survey indicated that GPs still believe that working relationships are somewhat important (n=3) and most Work and Income respondents agreed (n=5). However one Work and Income case manager indicated that a working relationship was not important at all. The participants did not elaborate when asked to give an explanation if their opinion had changed since the first survey.

[11] Copies of the surveys are available upon request

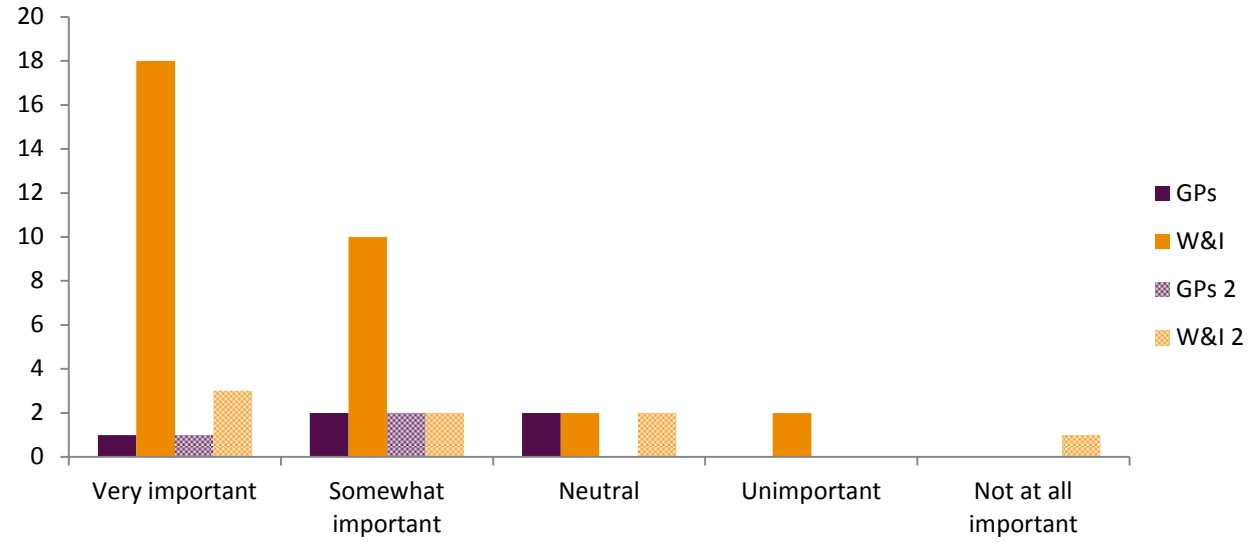

Figure 12: How important is it to have a working relationship with the other party when supporting clients/patients?

> *I can see how a relationship with the Doctor would definitely benefit in the processing of a client's benefit and specifically to ensure Full and Correct Entitlement for the client.* (Work and Income case manager)

These results suggested that the two parties agreed a relationship is important, but as further results indicate, do not understand how to foster this relationship.

Frequency and type of contact

The survey investigated the frequency of contact that occurred between the two parties over the last six months. Participants from Work and Income had mixed responses, with one stating that they contacted GPs daily. This respondent identified themselves as the Regional Health Advisor, a role which includes frequent contact with GPs. Most others (n=28) stated that they contacted a GP less than once a month or not at all. Most of the GP respondents (n=4) also stated that they contacted a Work and Income representative less than one time per month or not at all (Figure 13). Follow up survey results displayed the same pattern with most respondents indicating they had contact less than one time per month or not at all. Once again participants did not indicate that the frequency of contact had changed.

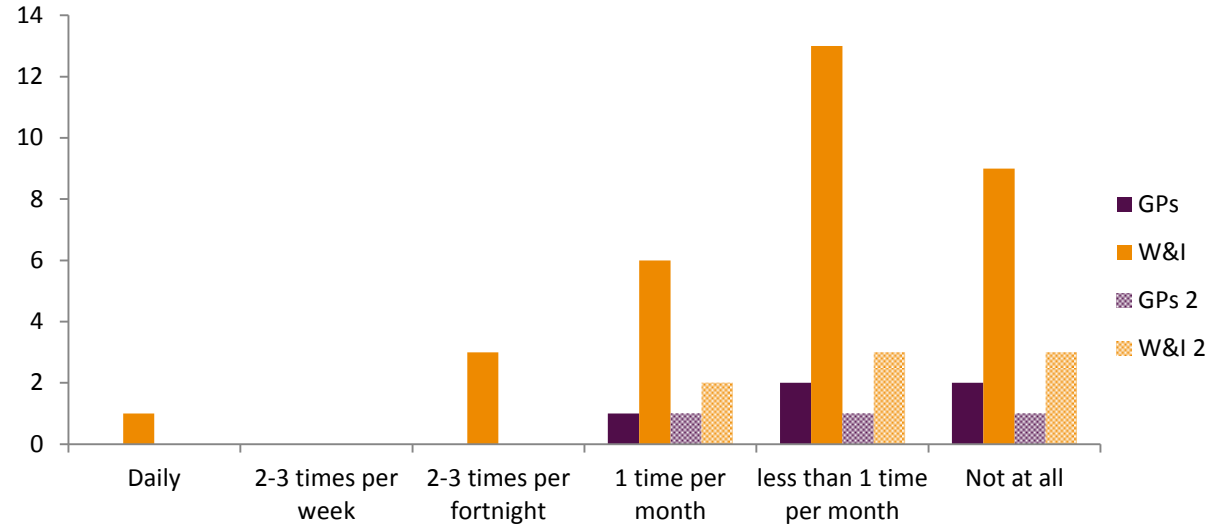

Figure 13: In the last six months, how often have you contacted the other party in relation to a client?

Respondents were also asked how often they were contacted by the other party in regard to the patients or clients in the last six months. Participants from Work and Income had a mixed response. A small number stated that they were contacted by a GP up to once per month (n=4), while most (n = 22) stated that they are contacted by a GP less than once per month or not at all. Three GP respondents also stated that they had not been contacted by a Work and Income representative, while two stated that infrequent contact occurred once a month or less (Figure 14). Results from the follow up survey also showed that there is little contact between the two parties (GP, n=2; Work and Income, n=7).

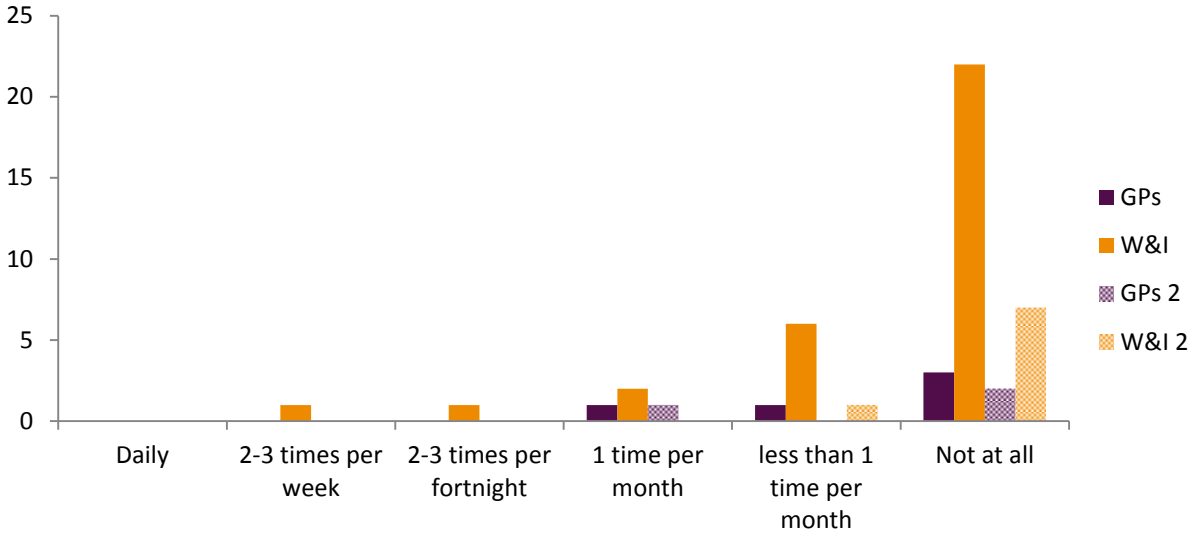

Figure 14: In the last six months, how often are you contacted by the other party in relation to a client/patient?

In the baseline survey GPs said they preferred telephone contact directly to them or a staff member at their practice. Most (n = 21) Work and Income staff said they preferred to be contacted by email (Figure 15). This was not asked again in the follow up survey.

Figure 15: Preferred mode of contact

GPs were also asked if they had a regular key contact at Work and Income. In the baseline survey three stated that they talked to whoever was available and the remaining two stated that they did not contact Work and Income. One GP related a recent positive experience with a Work and Income case manager who had helped the GP support a patient who needed to go on an Invalid's Benefit. There were no changes in responses in the follow up survey, with one GP indicating that they did not contact Work and Income and the other two indicated they talked to whoever was available.

Overall these results show that contact between Work and Income and GPs regarding client/patient information was very infrequent. One reason could be their preferred mode of contact. GPs could prefer a telephone call or telephone message because they may not have time during the day to access and reply to emails. In contrast Work and Income preferred email contact as they can choose when to reply if busy. Connecting GPs with a key representative, as well as a backup key contact in their local Community Link office, could be a strategy to improve communication frequency and quality.

Information Sharing

Respondents were asked what type of information they shared with the other party. Work and Income case managers said they typically contact GPs to discuss the client's condition which is inhibiting work, clarify conflicting or unclear information on medical certificates or gather other information relevant to the client's health condition. One Work and Income case manager discussed a client's benefit situation with their GP over the phone call during a client's appointment. The presence of all three parties gave the case manager and the GP the opportunity to clarify the information needed from each person, while drawing on the relevant information already on file. However, some responses indicated that Work and Income do not share information with GPs, as they believed this to be the role of the Regional Health Advisor.

Usually I am seeking clarification of some aspect of the medical certificate. I only discuss information relevant to client's benefit/Disability Allowance or working capabilities. When more than the basics is required, communication with the Ministry's Regional Health Advisor is better given we are not medical experts. That relationship is more than valuable. (Work and Income case manager)

GPs also stated that they share information relevant to illness and condition or discuss medical certificates. Specifically, one GP stated that the information they shared was to aid Work and Income's understanding and service, but it was very important that the information was kept confidential.

For WINZ to function properly they need to understand where the patient is coming from so need to understand the medical conditions. We need to be able to explain these with confidence that a) the case officer will understand the medical terminology and b) that WINZ will keep all information given strictly confidential. (GP)

In the follow up survey all GPs indicated that the information they share with Work and Income identifies how the patient's medical condition impacts on their work capacity. Most Work and Income respondents indicated that the information they discuss with GPs is related to understanding conflicting or unclear information, such as follow up dates, that was not directly related to work capacity on medical certificates (n = 5). Several others said they discuss additional information about how a client's condition is inhibiting work with GPs (n=4). Two other Work and Income respondents indicated that information shared was to understand a client's health condition and information relating to a client's benefit situation. The response options were created from the open ended responses received in this section in the baseline survey and respondents could choose multiple answers.

Each party was asked how confident they were that the other party or service could provide support for the client/patient. In the baseline survey GPs were neutral or unconfident that Work and Income could provide support, while most Work and Income representatives were very confident or somewhat confident (n = 22) that GPs could support their clients (Figure 16). The follow up survey showed confidence varied in both GPs and Work and Income employees, ranging from somewhat confident to very unconfident.

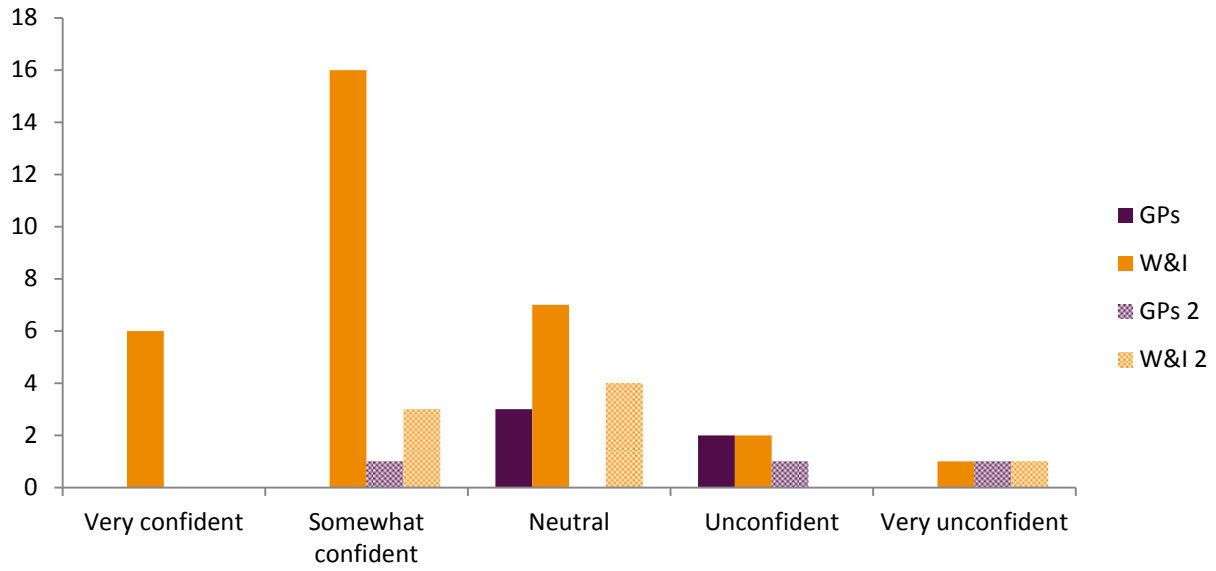

Figure 16: How confident are you that the other party can provide appropriate support for your patient/client?

Both parties were also asked about their comfort in sharing or asking for information in the baseline survey. Work and Income representatives indicated they were very comfortable or comfortable (n=21) or neutral (n = 7) about sharing information with GPs. Four indicated they were uncomfortable or very uncomfortable sharing information with GPs. However, GPs were either neutral (n = 2) or uncomfortable (n = 3) about sharing information with Work and Income.

In the follow up survey, two GPs indicated that they were uncomfortable sharing a client's personal information with a Work and Income representative. While Work and Income representatives indicated they were very comfortable (n=3), somewhat comfortable (n=3), or neutral (n=2) about contacting GPs for health information related to clients' benefit or employment needs. None of the respondents utilised the open response area to elaborate on how their comfort level had changed since the baseline survey.

In the baseline survey Work and Income representatives were asked to recall times where they could have provided a better service if a client's information had been shared with the GP. Generally respondents indicated that doctors needed better practice around filling out medical certificates. One respondent suggested that doctors would benefit with more instruction and information on how to complete a certificate correctly. Areas relating to improved practice regarding medical certificates included:

- dating the certificate as the date on which the client's benefit expired, when applicable,
- listing the date that an Invalid beneficiary's condition should be reassessed (usually two years), rather than the date of the next medical review or appointment,
- more information regarding a patient's medical status, allowing Work and Income to assess all eligibility, and
- having nurses who were able to assist with medical certificate questions when the doctor is unavailable.

One case manager believed they could provide better support to their clients if they received more information from GPs, such as a wellness plan or information indicating that the client had been referred to further support services.

> *I have a concern regarding how depression and other mental illnesses can affect a client's ability to work and do not see any other ongoing support for the client such as a referral to a specialist, counsellor or other agencies from the client's GP. …We generally don't know what extra support a client is getting. If a client came to an appointment with a form or letter or wellness plan it would make it much easier to better support our clients.* (Work and Income case manager)

One respondent suggested that if GPs faxed Designated Doctors reports straight to the office once completed, it would save stress and financial hardship on the client. Another respondent noted that if levels of information sharing were increased, clients would be served in timelier manner.

> *As we move more into Welfare Reform I think the level of information sharing may need to increase between Work and Income and doctors. I am the liaison person for referrals from Workwise for the Sickness Benefit cohort. It would be better if, at first contact, the client gives full consent for each of the four partners (GP, supported employment provider, Work and Income, and the client) to discuss the client's benefit and health issues. [All partners should] have a planned approach and work toward that.* (Work and Income case manager)

Some GPs provided additional feedback on their current relationship with Work and Income. One stated that Work and Income should not send patients on permanent invalid benefits for regular review. Another said that, despite providing a lot of information about their clients and trying very hard to facilitate dialogue with Work and Income, they have not responded to requests for contact and the structure of the system is a barrier to patients.

> *In general Work and Income do not contact the GP. They are unhelpful to the patients. They do not come forward with what a patient is entitled to receive. Patients seem to be endlessly filling out ridiculously complicated forms - this is difficult when you are unwell and even more so if you have an intellectual disability or are not well educated. The vast majority of patients are not trying to abuse the system yet they are made to feel like criminals. We do not put patients on invalids' benefit lightly but, again, are often made to feel totally incompetent and as if we are complicit in enabling people to abuse the system when we do! WINZ does not pay well, most people would in fact like to be in work if they could - the pay is certainly better. People do not fit in boxes. Each person must be treated as an individual. Each individual's ability to cope with illness is different.* (GP)

Limitations

These results and conclusions were drawn from a relatively small sample size. Only five GPs, out of approximately 15 working full or part time at the Newtown or Waitangirua practices, responded. Additionally, as this survey was targeted to the Community Link case managers and GPs participating in this evaluation, it may not reflect the views of other Work and Income representatives or other general practitioners. The results and conclusions of the follow up survey are further limited by the very small number of respondents.

Conclusions

Overall, results from the baseline survey indicate there may not be enough clarity about the type of information that is to be shared between the two parties, which could lead to reluctance to contact the other party. Further results indicate that while most Work and Income representatives are confident in GPs' ability to support their clients and also comfortable in sharing information with them, the trust was not returned by GPs. This suggests the relationship between these two parties is inconsistent. The GPs' lack of trust was also demonstrated in their low comfort levels of sharing information with Work and Income staff. GPs comments suggested that concerns around privacy, confidentiality, and the lack of clarity around the kind of information that can be asked from one another may contribute to the lack of trust. Additionally, GPs did not appear to be familiar with the organisations' rebranding, referring to Work and Income as WINZ. Results of a follow up survey indicate there has been little or no change in the importance of a working relationship or frequency or quality of communication between Work and Income and GPs.

Trust and confidence are two factors that help lead to good communication between partners. Developing trust through better communication will likely to improve these relationships and may lead to a stronger partnership. Creating guidelines around information sharing and best communication practices, while allowing for flexibility to respond to individual styles may be useful. Initial clarity may help both GPs and Work and Income case managers more confidence to increase quantity and quality of communication. Successful communication can increase trust, and trust will also lead to improved communication.

Appendix: Participant characteristics

Table 5: Participant characteristics

	Length of time in role		Time spent working in Wellington	
	GP	Work and Income	GP	Work and Income
Less than 1 year	0	2	1	3
1-2 years	1	5	0	3
3-5 years	0	3	1	3
5-10 years	1	18	1	16
More than 10 years	3	4	2	7

Table 6: Participant characteristics at follow up survey

	Length of time in role		Time spent working in Wellington	
	GP	Work and Income	GP	Work and Income
Less than 1 year	0	1	0	2
1-2 years	1	2	1	2
3-5 years	0	0	0	0
5-10 years	0	4	0	3
More than 10 years	2	1	2	1

Appendix D: Interview schedules

Interview schedule for clients

*Introduce yourself, thank the client and then talk though participant info sheet, consent form, any questions. If talking to a client who did not participate, skip questions marked with asterisks** and conclude interview after part one.*

Part one: Factors that lead to participation or declining

- Ask client to state their name and age for the record.
- Thinking back to when you were asked to take part in the employment programme, how did you find out about it?
- Who talked to you about accepting a referral? Was the EC present?
- What was that/were those conversation(s) like? Establish client's **BENEFIT STATUS**
    - Prompts: How did you feel? (comfortable, awkward, etc?); competence/qualities of GP, (*signs of coercion*), cultural appropriateness
- Can you tell me about the reasons you chose (not) to take part?
    - E.g. EC organisation delivering the service, location of practice, availability of EC or participant, cultural appropriateness, values, involvement of Work and Income, interest in work/study?
- How did you feel when you made your decision?
- Did you have any worries/concerns that impacted your decision?
    - E.g. general anxiety because you didn't feel ready to work? Why--lack of education or work experience, fear of failure or application forms, employers bias, societal stigma, lack of interviewing skills (*signs of coercion*)
    - Were these addressed by your referrer (or by the EC, if present)?
- What were you doing before the conversation? (If not already discussed)
- **What were/are you hoping to happen as a result of working with [*EC*]?
- **Was your decision influenced by other people? In what ways?
    - Prompt: family/partner/ friends, etc.?
- Do you have any suggestions about how to improve the way people are approached in the future?

Stop here if client did not participate*

Part two: During the programme

- How confident did/do you feel that you could/can achieve (*result client spoke about above*)?
    - Can you tell me about any concerns/barriers?
- What were the things that keep you interested and involved?
    - Personal factors, e.g. own interest, belief in self, supportive friends & family, increased confidence after positive steps taken
    - Organisational factors, e.g. input from GP, EC and Work and Income
    - System factors, personal support as well as organisational and input from.
- Were there any times that you felt discouraged/frustrated/scared? What helped you get through those?
- What things helped you to maintain your relationship with the EC, GP, (Work and Income)?
- How did your EC help you think about telling your employer about your health condition?

Part three: Outcomes

- What do you feel you have achieved as a result of participating in this programme so far?
- What do you think has led to your achievements so far?

    - Probe: personal factors: e.g. abilities, interest, confidence, sense of hope, EC (EC's personality AND model of programme, e.g. 1:1 support), GP/other health professionals, Work and Income support
- (If they're on a benefit) In what ways has your relationship with Work and Income changed?
    - Probe: what has contributed to these changes (if any)?
- What could the Workwise consultant do better to support you/others in the future?
    - Work and Income
    - Your GP/health provider (AND practice)

Anything else the client would like to add? Or questions they thought we would ask but didn't? Thank the client for participating and conclude interview.

Interview schedule for high level staff

Introduce yourself, thank the participant and then talk though participant info sheet, consent form, any questions. If talking to a key informant that was involved in the on the ground implementation, please also consult other schedule.

Part one: Vision and Purpose

- Ask participant to state their name and role for the record.
- Can you tell me a little bit about your role?
- And the role of your organisation?
- What is your role in the programme?
- Could you say a bit about the purpose of this programme?
    - Prompt: goals
    - outcomes
    - hoping to achieve, as an organisation or overall
    - vision for future

Part two: Establishing partnership

- What previous knowledge did you have about getting a partnership started?
- Can you tell me about how the partnership was formed?
    - What was your role in establishing it?
    - Can you give me examples of meetings, planning or communication around key phases? E.g. scoping, planning, or signing agreements?
    - Were leaders and managers identified?
    - How were the roles and responsibilities of each partner determined? If duplication was considered to be a risk, how was this addressed?
- Can you give me examples of the plans that were put in place (written or otherwise) to facilitate joint working?
    - If nothing-- what could have helped/will help in future?

Part three: Partnership during the programme

Managing and maintaining

- How did you learn about the partnership? (if not already clear)
- Can you give me an example of the ways that communication between organisations was maintained or facilitated?
    - E.g. regular meetings or communication occurring between management or other strategic staff?
- Has this information been used to guide decisions about the programme? In what ways?
- How was the information gained in these meetings or information about the vision/purpose of the programme communicated to staff?
- Can you give me an example of sharing, i.e. resources & information between the organisations?
- How clear are the roles and responsibilities of the partners at this point in the partnership? Are you aware of any service duplication?

Review and revise

- In what ways has the strategy or vision changed since the partnership began?
    - How was the need to revise this determined?
- What challenges have you experienced in the partnership?

- How did you respond to these?
- How did the response fit with any plans that were created to deal with challenges (if any)?
- Did you share these challenges or any other upcoming concerns with the other partners?
    - If so, how did they support you to resolve these?
- Would you consider involving the other partners in dealing with challenges or issues in the future?
    - What type of support do you think would be helpful to you?

Part four: Outcomes

- Can you describe any achievements of the partnership to this point?
    - Has it added value to your organisation?
- In what ways, if any, have clients/patients benefitted due to the support offered?
    - E.g. steps to employment, general wellbeing, etc.
    - How has partnership or joint working between GPs, Work and Income and the Employment Consultant contributed to this?
- What suggestions to have for improving the partnership or joint working for the future?
- In what ways, if any, do you see this benefitting the clients?

Anything else the participant would like to add? Or questions they thought we would ask but didn't? Thank the stakeholder for participating and conclude interview.

Interview schedule for Work and Income

Introduce yourself, thank the participant and then talk though participant info sheet, consent form, any questions. If talking to a key stakeholder that was involved in the high level implementation, please also consult other schedule.

Part one: Vision and Purpose

- Ask participant to state their name and role for the record.
- Can you tell me a little bit about your role?
- And the role of your organisation?
- Would you please describe how you were involved in this programme?
- What do you think the purpose of the programme is?
    - Prompt: goals or anticipated outcomes
    - What are you hoping to achieve, as an organisation or overall vision for future?
- In what ways were you supported by your manager or other leaders in your organisation with regards to your role in the programme?

Part two: Establishing partnership

- Did you receive any guidelines outlining process for establishing goals, communication or points of contact?
    - If not what, if anything, would have been useful?
    - If so, did you use these and how useful were they?

Part three: During the partnership

- Thinking about the processes that you go through to support a sickness benefit client into employment--who (agencies, GPs) do you contact when supporting a client?
    - ***Interviewer note: cover "communicating with GPs" then "communicating with agencies", then "all".***

Communicating with GPs

- Can you describe the guidelines or systems in place to communicate with GPs?
    - If no guidelines, would these be useful?

If doesn't contact GPs (or says role of RHA to talk to GPs)

- Can you describe how you decide to refer a case on to the RHA?
    - How often does this occur?
- What type of information does the RHA gain for you?
- In what timeframe do you usually expect the information to be returned?

If does contact GPs

- What type of contact method(s) do you use? E.g. e-mail, phone, etc.
- How often do you try to contact them?
- What type of information do you discuss?

All

- What worked well about supporting clients by this type of communication?
- What didn't work as well about this type of communication?
- Are there any ways in which the processes could be improved?
- Can you tell me about a time, if ever, you were contacted by a GP?
- What would are the key two to three things that you think would be helpful for GPs to know about your processes in supporting sickness benefit clients into employment?

Communicating with other employment agencies (including Workwise)

- Can you give me any examples of how you've worked with external agencies (including Workwise) to provide employment support to a client?
    - How do you identify mutual clients?
    - What type of contact method do you use? E.g. e-mail, phone, etc.
    - How often do you try to contact them?
    - How often are you contacted by them?
    - What are the typical types of conversations or questions you might ask/answer? (type of information discussed)?
    - What type of guidelines or systems, if any, provide a structure for this communication?
        - If no guidelines, would these be useful?
- What worked well about supporting clients by this way of working?
- What didn't work as well about this method of communication?
- Are there any ways in which the processes could be improved?
- How do you ensure that services aren't duplicated?

Part four: Outcomes

- Can you describe any achievements of the partnership to this point?
    - Did this programme improve the working relationship between the partners?
    - Has it added value to your organisation? To the clients?
- Do you have any suggestions about how to improve the ways in which you communicate and share resources with Workwise (and/or GPs, if the other not discussed) to help clients?
    - Clearer guidelines, an organisational contact
- Do you have any suggestions for future improvement?
    - Information shared
    - Communication
    - Working together
    - Systems

Anything else the participant would like to add? Or questions they thought we would ask but didn't? Thank the person for participating and conclude interview

Interview schedule for GPs

Introduce yourself, thank the participant and then talk though participant info sheet, consent form, any questions. If talking to a key informant that was involved in the high level implementation, please also consult other schedule.

Part one: Vision and Purpose

- Ask participant to state their name, role & practice for the record.
- Can you tell me about how did you learned of the partnership (became involved)? Why did you decide to participate?
- What do you think the purpose of the programme is?
    - Prompt: goals or anticipated outcomes
    - What are you hoping to achieve, as an organisation or overall vision for future
- In what ways were you supported by your manager or other leaders in your organisation with regards to your role in the programme?

Part two: Establishing partnership

- Did you receive any guidelines outlining process for establishing goals, communication or points of contact?
    - If not what, if anything, would have been useful?
    - If so, did you use these and how useful were they?

Part three: During the partnership

- Can you tell me about a time you decided to talk to a patient about employment?
    - How did the topic come up? (recruitment/patient ID)
    - How did you decide whether or not to refer a patient? ***Implicit & explicit referral criteria***
    - Is this typical or are there any differences? What if you're unsure re referral?
    - Are there times where the conversation didn't go well?
        - What reasons have patients given for not accepting a referral/talking about work?
- Can you think of an example where you've referred a client to the EC?
    - How do you know whether or not your referral has been accepted?
    - How often do you discuss patients with the employment consultant from Workwise?
    - Is it useful to have her on site? Easy to talk to?
    - How are you informed of the patients' progress?
- Would you prefer communication to happen differently in any way?
- Who, if anyone, do you contact when supporting a client on a sickness benefit?

Part four: Outcomes

- Can you describe any achievements of the partnership to this point?
    - Did this programme improve the working relationship between the partners?
    - Has it added value to your organisation? To the clients?
- Do you have any suggestions about how to improve the ways in which you communicate and share resources with Work and Income to help clients?
    - Clearer guidelines, an organisational contact
- If there were guidelines about how Work and Income should work with GPs what would be useful to put in the guidelines?
- Do you have any suggestions for future improvement?
    - Information shared
    - Communication
    - Working together
    - Systems

Interview schedule for employment consultant

Introduce yourself, thank the participant and then talk though participant info sheet, consent form, any questions. If talking to a key informant that was involved in the high level implementation, please also consult other schedule.

Part one: Vision and Purpose

- Ask participant to state their name and role for the record.
- Can you tell me a little bit about your role?
- And the role of your organisation?
- Would you please describe how you were involved in this programme?
- Can you describe the purpose of the programme?
    - Prompt: goals or anticipated outcomes
    - What are you hoping to achieve, as an organisation or overall vision for future?
- In what ways were you supported by your manager or other leaders in your organisation with regards to your role in the programme?

Part two: Establishing partnership

- Did you receive any guidelines outlining process for establishing goals, communication or points of contact with the GPs? With Work and Income?
    - If not what, if anything, would have been useful?
    - If so, did you use these and how useful were they?

Part three: During the partnership

- Thinking about the processes that you go through to support a client into employment--who (agencies, GPs) do you contact?

Interviewer note: cover "communicating with GPs" then "communicating with W&I".

Communicating with GPs

- Can you describe the guidelines or systems in place to communicate with GPs?
    - If no guidelines, would these be useful?
- What type of contact method(s) do you use? E.g. e-mail, phone, etc.
    - How often do you try to contact them? In what timeframe do you usually expect the information to be returned?
    - What type of information do you discuss?
    - What works well about this type of communication?
    - What could be improved?
- Can you describe a time you have worked with the GP to support a client?
    - What didn't work as well?
    - What didn't?
- Are there any ways in which the processes could be improved?
- Can you tell me about a time, if ever, you were contacted by a GP?
- What would are the key two to three things that you think would be helpful for GPs to know about your processes in supporting clients into employment?

Communicating with Work and Income

- Can you give me any examples of how you've worked with Work and Income to provide employment support to a client?
    - How do you identify mutual clients?
    - What type of contact method do you use? E.g. e-mail, phone, etc.
    - How often do you try to contact them?

    - How often are you contacted by them?
    - What are the typical types of conversations or questions you might ask/answer? (type of information discussed)?
    - What type of guidelines or systems, if any, provide a structure for this communication?
        - If no guidelines, would these be useful?
- What worked well about supporting clients by this way of working?
- What didn't work as well about this method of communication?
- Are there any ways in which the processes could be improved?
- How do you ensure that services aren't duplicated?

Part four: Outcomes

- Can you describe any achievements of the partnership to this point?
    - Did this programme improve the working relationship between the partners?
    - Has it added value to your organisation? To the clients?
- Do you have any suggestions about how to improve the ways in which you communicate and share resources with Work and Income (and/or GPs, if the other not discussed) to help clients?
    - Clearer guidelines, an organisational contact
- Do you have any suggestions for future improvement?
    - Information shared
    - Communication
    - Working together
    - Systems

Anything else the participant would like to add? Or questions they thought we would ask but didn't? Thank the person for participating and conclude interview.

References

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