



Barriers and facilitators of the implementation of Individual Placement and Support (IPS) for patients with offending histories in the community: The UK experience

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Abstract:	<p>Introduction: We aimed to identify the barriers and facilitators to the implementation of a high fidelity IPS service in a community forensic mental health setting.</p> <p>Method: In-depth interviews were conducted with clinical staff (n=11), patients (n=3), and employers (n=5) to examine barriers and facilitators to implementation of a high fidelity IPS service. Data was analysed using thematic analysis, and themes were mapped onto IPS fidelity criteria.</p> <p>Results: Barriers cited included competing interests between employment support and psychological therapies, perceived patients' readiness for work, and concerns about the impact of returning to work on welfare benefits. Facilitators of implementation included clear communication of the benefits of IPS, interdisciplinary collaboration, and positive attitudes toward the support offered by the IPS programme among stakeholders. Offences, rather than mental health history was seen as a key issue from employers' perspective. Employers regarded disclosure of offending or mental health history as important to develop trust and to gauge their own capacity to offer support.</p> <p>Conclusion: Implementation of IPS in a community mental health forensic setting is complex and requires robust planning. Future studies should address the barriers identified and adaptations to the IPS model are needed to address difficulties encountered in forensic settings.</p>

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3 **Barriers and facilitators of the implementation of Individual Placement and Support**
4 **(IPS) for patients with offending histories in the community: The UK experience**
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10 **Abstract**
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12 Introduction: We aimed to identify the barriers and facilitators to the implementation of a
13 high fidelity IPS service in a community forensic mental health setting.
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19 Method: In-depth interviews were conducted with clinical staff (n=11), patients (n=3), and
20 employers (n=5) to examine barriers and facilitators to implementation of a high fidelity IPS
21 service. Data was analysed using thematic analysis, and themes were mapped onto IPS
22 fidelity criteria.
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31 psychological therapies, perceived patients' readiness for work, and concerns about the
32 impact of returning to work on welfare benefits. Facilitators of implementation included clear
33 communication of the benefits of IPS, interdisciplinary collaboration, and positive attitudes
34 toward the support offered by the IPS programme among stakeholders. Offences, rather than
35 mental health history was seen as a key issue from employers' perspective. Employers
36 regarded disclosure of offending or mental health history as important to develop trust and to
37 gauge their own capacity to offer support.
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51 Conclusion: Implementation of IPS in a community mental health forensic setting is complex
52 and requires robust planning. Future studies should address the barriers identified and
53 adaptations to the IPS model are needed to address difficulties encountered in forensic
54 settings.
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Key words:

Individual placement and support, implementation, employment, offenders, mental disorder, barriers, facilitators.

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Introduction

The UK government regards employment as a means to aid mental health recovery and reduce reoffending rates (Ministry of Justice, 2013). Higher rates of unemployment exist among ex-offenders than in the general population, 47% and 12% respectively (Ministry of Justice, 2013). Nearly 60% of people released from prison re-offend within 3 years of their release (Pager, 2003) and among offenders sentenced to a prison sentence of under 12 months, higher reoffending rates are reported for those who do not enter employment than those who do, 69% and 32% respectively (Ministry of Justice, 2013). The combination of stigma attached to incarceration, social isolation, **substance use**, and low educational attainment serves to perpetuate an inverse relationship between incarceration and subsequent employment (Western, 2002). Furthermore, ex-offenders face additional personal and social barriers to employment, including homelessness, lack of relevant skills, stigma and discrimination from employers (Centre for Mental Health, 2010; Talbot et al., 2018; Haslewood-Pocsik et al., 2008).

Specific lack of employment opportunities for ex-prisoners with severe mental illness is well documented (e.g., Hamilton, 2016). While several work skills programmes have been developed for this population, these programmes are primarily delivered in criminal justice settings and the evidence base for their effectiveness is limited. For instance, Talbot and colleagues (2017) reviewed published literature to determine the effectiveness of work skills programmes and reported that these programmes had no significant impact on mental health, substance use or reoffending rates, and their impact on helping people enter paid employment was modest.

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6 Effective approaches to helping people with offending histories gain employment share some
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8 of the features of Individual Placement and Support (IPS) (Samele et al., 2018), a form of
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10 evidence-based supported employment. IPS is regarded as the most effective approach in
11
12 supporting people with severe mental illness to secure paid employment (Crowther et al,
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14 2001; Burns et al, 2007; Rinaldi et al, 2008; Bond et al, 2008; Kinoshita et al, 2013; Modini
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16 et al., 2016; Metcalfe et al., 2018; Frederick and Vander Weele, 2019). The IPS model
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18 originated in the USA, but research evidence suggests that IPS transports well to other
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20 countries provided that programmes achieve high fidelity to the IPS model (Bond et al., 2012;
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22 Catty et al., 2008). For instance, the EQOLISE study (Burns et al., 2007) demonstrated the
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24 effectiveness of IPS in six European centres (London (UK), Ulm-Guenzburg (Germany),
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26 Rimini (Italy), Zürich (Switzerland), Groningen (Netherlands), and Sofia (Bulgaria)). Other
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28 studies demonstrated the effectiveness of IPS in the Netherlands (Michon et al., 2014),
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30 Sweden (Bejerholm et al., 2015), and Switzerland (Hoffman et al., 2012). In the UK, the
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32 SWAN trial (Howard et al., 2010) found no significant differences between IPS and
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34 traditional vocational services in obtaining competitive employment at 1-year follow up.
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36 Only at 2-year follow up was IPS found to be more effective than the control intervention
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38 (Heslin et al., 2011). While high IPS fidelity was attained in the SAWN trial, the concern was
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40 that the implementation lacked sufficient dosage to be effective. This is important since an
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42 effective intervention delivered at sub-therapeutic dose becomes an ineffective intervention
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44 (Latimer, 2010).
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54 However, implementation of the IPS model in different social and economic contexts can be
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56 challenging and certain barriers may prevent IPS services from attaining high fidelity
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58 (Bergmarka et al., 2018; Nygren et al. 2011; Hasson et al., 2011). Of relevance to this
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3 discourse, are findings from studies that reported on the barriers and facilitators to IPS
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5 implementation in adult mental health settings.
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10 11 12 *Literature review* 13

14 The extant literature identified several contextual, organisational and individual level barriers
15 to IPS implementation (Bonfils et al., 2017). Key structural barriers include existing
16 regulations for social insurance and employment (Hasson et al., 2011), poor interagency
17 collaboration (Van Erp et al., 2007; Hasson et al., 2011), failure to provide employment
18 support, global economic recession (Rinalidi et al., 2010) and conflict between national
19 employment policies and local IPS schemes (Bonfils et al., 2017).
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33 Organisational level barriers are numerous and include lack of organisational standards,
34 inadequate funding and support for vocational programmes, lack of engagement from
35 healthcare managers, poor management practices, resistance to change, negative attitudes
36 among managers and clinicians about the feasibility of work for people with mental illness,
37 scepticism about the organisational fit of IPS, and difficulties related to integration of the IPS
38 service into local mental health teams (Bond et al., 2001; Van Erp et al., 2007; Hasson et al.,
39 2011; Bonfils et al., 2017; Bergmarka et al., 2018). Other studies reported additional barriers
40 like poor cooperation between employment specialists and mental health teams (Corbière et
41 al., 2009), limited knowledge of IPS among clinicians (Shafer et al., 1999), negative attitudes
42 towards employment among people with mental illness (Crane-Ross et al., 2000), limited
43 knowledge of mental health issues among employment specialists (Handler et al., 2003), and
44 reluctance of employment specialists to collaborate with clinicians due to feelings of
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3 intimidation (Handler et al., 2003) and concerns about the medical model predominating over
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5 the vocational approach to understanding the patients' problems (Drake et al., 2003).
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12 Individual level barriers are limited knowledge of supported employment among clients and
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14 family members (Bond et al., 2001), concerns about the impact of IPS on welfare benefits
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16 (Hasson et al., 2011), fears that transition to work will have a negative impact on the
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18 individual and a culture of low expectations (Rinaldi et al., 2010).
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24 Key facilitators of IPS implementation cited include the professional skills and dedication of
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26 IPS workers and the integration of IPS and mental health services (Van Erp et al., 2007;
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28 Bergmarka et al., 2018), the use of a fidelity scale to guide implementation and the
29
30 employment of skilled professionals (Bonfils et al., 2017). Further, Becker and colleagues
31
32 (1998) identified five areas that are critical for successful implementation of IPS; leadership,
33
34 organizational structure, training, finance, and time frame.
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40 **Research on IPS implementation is an emerging field. Bonfils and colleagues (2017)**
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42 **identified a lack of focus on the contextual differences between countries in relation to health,**
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44 **employment, social care and welfare systems as a major limitation of studies of IPS**
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46 **implementation (Bonfils et al., 2017). However, more recent studies addressed that by**
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48 **focusing on contextual differences (e.g., Metcalfe et al., 2018; Richter & Hoffman, 2018).**
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53 ***The present study***

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56 Community forensic mental health services in the UK provide treatment for individuals with
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58 mental disorders and offending histories, and aim to help individuals who are discharged
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3 from secure care make the transition back into the community (Joint Commissioning Panel
4 for Mental Health, 2013). These services first began to evolve in 1992 and by 2006 there
5 were 37 services in England and Wales alone (Judge et al., 2004). Whilst all services offered
6 risk assessment and case management, only half offered specific psychotherapeutic
7 interventions, some offering treatments for personality disorders (40%), sex offenders (36%)
8 or substance use (16%) (Judge et al., 2006). More recently, the Royal College of Psychiatrists
9 set quality standards for these services (Kenney-Herbert et al., 2013), but the extent of
10 adherence to these standards remains uncertain.
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26 Whereas IPS is regarded as 'best practice' in adult mental health, the evidence base for IPS in
27 forensic mental health settings is limited (Sneed et al., 2006). A notable exception is a study
28 in the USA by Bond and colleagues (2015) which reported that IPS was superior to a control
29 intervention that offered a job club approach with peer support in helping people with justice
30 involvement secure competitive employment. However, the study reported no significant
31 difference between the interventions in relation to justice involvement. More recently,
32 Durcan and colleagues (2018) examined the effectiveness of IPS among prison leavers and
33 reported that out of the 54 people who actively engaged in IPS, 21 (39%) gained paid
34 employment.
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51 However, little is known about the barriers and facilitators to IPS implementation in criminal
52 justice or forensic mental health settings. A study from the USA (Sveinsdottir and Bond,
53 2017) reported on barriers to employment in people with severe mental illness and criminal
54 justice involvement, and identified poor engagement with vocational services as the main
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3 barrier to employment in this population, followed next by substance use. The study,
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5 however, did not discuss barriers and facilitators of IPS implementation. The present study
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7 helps fill an important gap in the literature and complement the findings of an earlier paper
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9 (citation) which described the process of IPS implementation in community forensic mental
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11 health settings. Using a qualitative research design, this paper provides further insights into
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13 the barriers and facilitators of IPS implementation in such settings through in-depth
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15 interviews with a sample of clinical staff, patients, and employers.
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21 *Study objectives*

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23 The specific objective of this study was to identify perceived barriers and facilitators to the
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25 implementation of high fidelity IPS programmes in community forensic mental health
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27 settings. The data is based on in-depth interviews with clinical staff, an employment
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29 specialist, employers, and patients.
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35 **Method**

36 *Design*

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38 The study was conducted as part of a feasibility cluster randomized trial of IPS in a large
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40 community forensic mental health service (blinded citation), including four clusters:
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47 Cluster 1: City Community Forensic Service.

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49 Cluster 2: County Community Forensic Service.

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51 Cluster 3: City Personality Disorder Network.

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53 Cluster 4: County Personality Disorder Network.
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3 Clusters 1 and 4 were randomly assigned to the intervention (IPS + treatment as usual
4 (TAU)), and clusters 2 and 3 to the control group (TAU). TAU comprised case management
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6 (Clusters 1 and 2) or therapy only (Clusters 3 and 4).
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10 11 12 *IPS implementation* 13

14 Details of IPS implementation and fidelity reviews are reported elsewhere (citation). It is
15 important to distinguish implementation from fidelity reviews. Implementation entails
16 transferring an effective programme into real world settings and maintaining them (Durlak
17 and DuPre, 2008). In contrast, a fidelity review is an important aspect of implementation
18 quality and assesses the extent to which a programme, in this case the IPS model, follows the
19 eight principles of IPS (Bond et al., 2012).
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30 The IPS model was implemented over 6 months. We used the Consolidated Framework for
31 Implementation Research (CFIR; Damschroder et al., 2009) to guide the process of IPS
32 implementation. The CFIR is comprised of five unified constructs: characteristics of the
33 intervention, inner setting, outer setting, individuals involved, and implementation process.
34
35 IPS fidelity reviews were completed by an independent IPS expert at the start and end of the
36 implementation period using the IPS fidelity scale (Becker et al., 2008). IPS was delivered by
37 an employment specialist who received supervision from a senior occupational therapist. An
38 IPS steering group, chaired by a senior occupational therapist, was established to oversee the
39 IPS implementation and delivery. A fair degree of fidelity (total IPS fidelity score=85) was
40 achieved at the end of the implementation period. Table 1 provides a detailed breakdown of
41 IPS fidelity scores.
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Table 1 Here

Sample

A sample reflecting a mix of backgrounds and experiences, including staff (n=11), patients who received the IPS service (n=3), and employers (n=5), participated in in-depth interviews that examined views of IPS, and structural, organisational, and individual level barriers and facilitators to implementation of IPS in community forensic mental health settings.

Patients aged 18 years or over who were on the caseload of the community forensic services were eligible to participate. Those who were unable to provide informed consent, not entitled to work in the UK, currently in open employment or who did not wish to work were excluded. Patient recruitment took place over 6 months, and participants were followed up for 12 months from enrolment date. We set no exclusion criteria for staff or employer participants.

Eighteen patients participated in the feasibility trial – 7 in the control arm and 11 in the IPS arm. Patient interviewees (n=3) were drawn from the IPS arm, all were male. Two had degree level qualifications and were in paid employment, and one in a volunteering role at the time of the interviews.

Staff participants were recruited from the IPS arm of the community forensic mental health services and therefore had knowledge and experience of the IPS service, including community psychiatric nurses (n=9), a psychiatrist, and the employment specialist within the service.

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3 Employer participants were recruited randomly from a list of employers compiled by the
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5 employment specialist during the study. Only two employers had direct experience of
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7 employing patients via IPS.
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10 11 12 ***Procedure***

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14 Semi-structured interviews were conducted in private rooms within the community forensic
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16 service, or at the work place of employer participants. Interviews were conducted by a
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18 researcher and members of a 'Lived Experience Advisory Panel' (LEAP) who had received
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20 training in conducting the interviews. The interview schedule for staff and patient
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22 participants covered topics related to the participant's personal experience of IPS and barriers
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24 and facilitators to IPS implementation. The employer interview schedule covered topics
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26 related to their personal experience of employing people with mental disorders and offending
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28 histories, and barriers and facilitators to employing these individuals.
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35 36 ***Research ethics***

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38 The study received approvals from the East Midlands research ethics committee and the
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40 Research and Innovations Department of the NHS Trust. Written informed consent was
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42 obtained from all participants.
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47 48 ***Data analysis***

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50 The interviews were audio recorded and transcribed verbatim. The data was then imported
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52 into Nvivo 11 Pro data software managing tool. Data familiarisation entailed listening to the
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54 audio recordings and reading the transcripts prior to analysis. The analysis was conducted by
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56 researchers who were not involved in the data collection. Interviews were analysed using
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58 Braun and Clarke (2006) thematic analysis. The resulting themes were mapped on to IPS
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3 fidelity criteria. The benefit of this approach is that it helps separate barriers and facilitators
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5 to IPS implementation from aspects of IPS programme fidelity that have not been adequately
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7 implemented. The findings were then discussed in the LEAP meetings to further validate the
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9 results. The LEAP group met quarterly with the research team to provide advice on IPS
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11 implementation and the overall conduct of the study.
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17 **Results**

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19 The results are presented under separate headings in accordance with the IPS fidelity criteria
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21 (Becker et al, 2008) which when achieved act as a facilitator, and when not a barrier. The
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23 data is from staff (S), an employment specialist (ES), employers (E), and patients (P).
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29 Zero Exclusion: To ensure fidelity, all clients interested in working should be offered IPS,
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31 regardless of job readiness, symptoms, violent behaviour, or treatment non-adherence. Clients
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33 should not be screened out or excluded.
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38 However, staff reported that some of their patients were not ready for employment, although
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40 part of the process of embedding IPS into a service, and to get referrals of patients by clinical
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42 staff, was to host workshops and seminars as training is critical to the success of IPS
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44 implementation (Becker et al., 1998), which not only detailed what IPS consisted of, but also
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46 the associated patient-centred benefits. Even with this knowledge, staff still judged whether
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48 their patient was ready for work or not and made authoritarian decisions which were not
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50 patient-centred:
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54 *S1: Some [clinicians] thought that employment wasn't really like a goal for some of*
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56 *their patients, and maybe they were reluctant to listen, I guess, about IPS because*
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58 *they don't feel that employment is something their patients are working towards.*
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6 Others described the challenges of offering IPS to patients who weren't regularly engaging
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8 with a service, although the zero exclusion criterion includes people who are not adherent to
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10 treatment:

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12 *S6: ...for patients that have not engaged and were discharged because we can't offer*
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14 *them a service, there's just nothing to offer them ... they probably wouldn't have been*
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16 *offered IPS because they wouldn't have engaged with the regular service to start with.*
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21 Staff also reported that the timing for IPS should come after a certain level of stability had
22
23 been achieved, via other therapeutic interventions which they felt was their primary job role:

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26 *S12: ...sort of thought actually this person is particularly unstable and yes we want to*
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28 *encourage them to work, but actually they probably need to engage with us and do a*
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30 *bit more therapy.*
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35 Therefore, although occupation is a significant facilitator to recovery for mental health, this
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37 participant regards therapy as the primary intervention, and is therefore working from a
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39 medical model of care, which could lack of focus on employment in a person's clinical
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41 treatment and recovery journey. This prioritisation of therapy is not only evident from staff
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43 narrative though. One patient believed that any success of the programme was down to the
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45 counselling group he attended that showed him peers who had achieved success despite their
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47 struggles:
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51 *P1: Group therapy gave me a lot more confidence seeing that there were people in*
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53 *the group that perhaps struggled more with confidence or, and that they were still*
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55 *functioning members of society and perhaps I need to give myself a kick up the*
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57 *backside and go do something ...*
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6 These organisational level barriers have been supported in the literature which cites negative
7 attitudes among managers and clinicians about the feasibility of work for people with mental
8 illness (Bond et al., 2001; Van Erp et al., 2007; Hasson et al., 2011; Bonfils et al., 2017;
9 Bergmarka et al., 2018), limited knowledge of IPS among clinicians (Shafer et al., 1999), and
10 negative attitudes towards employment among people with mental illness (Crane-Ross et al.,
11 2000). There is also an individual level barrier to IPS, in that patients may fear the transition
12 to work will have a negative impact on them (Rinalidi et al., 2010):

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21 *P3: I basically told the employment specialist that I needed a month, I'm just not*
22 *going to contact her, not hear from you for a month, I need to reset, I need to not*
23 *apply to anything and just take it easy for a while.*

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31 However, enablers to recovery includes having a meaningful life, hope, empowerment and
32 social integration (Burhouse et al., 2015) all of which occupation can provide, and can
33 provide structure, and improve self-esteem (Boyce et al., 2008). These enablers are evident in
34 patient's narratives who believed that the activities they did brought benefits to their lives
35 including providing some meaning and focus and to motivate them to engage in purposeful
36 activity during their day:

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45 *P1: I kind of wanted a job and to feel some meaning in my life again, to have a*
46 *purpose, umm I didn't know how that was going to work.*

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51 Occupation as an enabler to recovery was also acknowledged by staff:

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S5: He needs less support and that all comes together you know and the staff they
recognise that he's out, he's doing stuff meaningful to his day, he's got a schedule,
he's got a routine you know and I really hope we can just build on that.

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5 An individual level barrier to the success of an IPS program is that the patient group has a
6 culture of low expectation (Rinalidi et al., 2010). The employment specialist through the
7 provision of support can counteract this and increase a patient's self-esteem so that they feel
8 that they can apply for work:
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17 *P3: ... led to me handing out some CVs at, at different pubs and I got an interview at,*
18 *well I think I handed out...I think 3 CV's and I got 2 interviews...*
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24 However, some staff report having a conversation with their patients about employment and
25 when the patient has been interested has referred them on:
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28 *S9: I haven't had much experience in finding any work for patients because not many*
29 *of mine have been that interested in finding work. Those that have, I've just passed*
30 *straight over to the IPS team and I haven't done a great deal really.*
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38 Furthermore, when patients were referred and accessed IPS, and thus reached good fidelity,
39 staff perceived employment positively:
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42 *S3: In my opinion it's something that is incredibly overlooked, that seems so simple.*
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47 Another exclusion based on staff perspectives was the lack of work experience, qualifications
48 or CVs amongst their patients:
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51 *S2: The lack of work experience that people have, so for a lot of the client group that*
52 *we have, they might be in their mid to late thirties, might be younger than that but*
53 *have no work history ... they get caught in you know just thinking that work is not an*
54 *option for them and their confidence is poor, their numeracy and literacy is poor...*
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6 However, factors such as gaining work experience and writing a CV are part of the IPS
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8 programme.

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10 *ES: ... we're working with people that have no CV to be able to demonstrate to*
11 *employers that they're capable of working so I think there have been some useful*
12 *adaptions made ... unpaid voluntary work's been approached and that's actually*
13 *been a, a really helpful way of getting people a CV started.*
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21 *Integration of Rehabilitation with Mental Health Treatment through Team Assignment:* For
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23 IPS to be successfully implemented, the Employment Specialist must be fully integrated
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25 within the mental health team that they are working with. This includes attending mental
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27 health treatment meetings, and having regular communication with the mental health
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29 practitioners. It appears in the narrative that some staff did not see IPS as integrated, and that
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31 it is external to their rehabilitation work:
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35 *S10: ... maybe it would be better and could actually add more to it if you had a better*
36 *dialogue between [the employment specialist] and us about what [the employment*
37 *specialist was] currently doing and where [the employment specialist was] at and*
38 *also hearing from [the employment specialist], what's useful and what's not...*
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47 Staff also discussed the challenges of fitting in a discussion about a patient's employment
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49 aspirations and how the IPS service could assist into the time-limited service that they offered
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51 to patients:
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54 *S3: ...it wouldn't be appropriate for an IPS worker to sit in on therapy sessions, so*
55 *that must be tricky and I think probably the barrier then is like well do you have to*
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3 *create another forum to talk about people... in the limited time that you have, you*
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5 *don't want to add that many more meetings than you have to.*
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10 Therefore, this participant regards the IPS worker as external to their work. This barrier has
11 been borne out in the literature which cites scepticism about the organisational fit of IPS and
12 difficulties in integrating it within mental health teams (Bond et al., 2001; Van Erp et al.,
13 2007; Hasson et al., 2011; Bonfils et al., 2017; Bergmarka et al., 2018). This organisational
14 level fit barrier is also demonstrated in the below:
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21 *S12: I think so yeah, enough time for people to get their head around it [the IPS*
22 *service], think how it was going to work, there was enough sort of warning*
23 *beforehand and to sort of ask questions have fears allayed sort of thing before getting*
24 *going with it.*
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33 Staff were generally unclear about the appropriateness of IPS within their services, thus
34 preventing integration. This appears to have been exacerbated by pre-existing attitudes to
35 IPS, and some of the ways in which IPS was communicated and promoted. Members of staff
36 recalled how a senior member of staff made comments that were 'unhelpful':
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45 *S1: ...I think it was a consultant who said that IPS has caused a patient to relapse and*
46 *go to prison but were unsure of who this person is, so we don't really have any*
47 *information.*
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54 Accounts such as this regarding IPS had a knock-on effect amongst other staff about the
55 benefits of IPS and other forms of supported employment for this patient group:
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3 *S6: ... saying negative things about a service it then makes it more difficult to*
4 *establish things... I think there was a danger of it leaving other staff with a negative*
5 *view of IPS and the notion of paid employment.*
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12 These statements infer that people were excluded due to fear of adverse effects, and limited
13 knowledge of IPS among clinicians which is a cited barrier to implementation of IPS (Shafer
14 et al.,1999). It also indicates that this fidelity factor was absent. If the employment specialist
15 was fully integrated with regular communication these negative issues could have been
16 resolved, as can be seen in the below:
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24 *S2: I think one of the huge positive factors was [the team leader] who was really keen*
25 *to embed it and really supported the employment specialist from a clinical*
26 *perspective, he's kept it on the agenda of all staff.*
27
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33 Where there was clearer communication of the benefits of employment and close working
34 between the IPS employment specialist and staff integration was achieved:
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40 *S12: I think the clarity of information around what IPS was and what the aim of it*
41 *would be I think helped get people on side I think. It definitely was a big plus having*
42 *someone embedded within the team.*
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49 Once staff believe in IPS as a rehabilitation intervention, they found that having an
50 employment specialist who would act as the person who knew and could support
51 employment, when their own job had multiple priorities was extremely useful:
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56 *S3: when I worked in the team as an [job role] that was one of the biggest challenges*
57 *was trying to support people to find that way back into work and to have somebody*
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3 *specialised in doing that is brilliant and really useful and takes away from even that*
4
5 *sense that people in service are always going to be in service.*
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10 Staff also commented that colocation of the employment specialist within teams enhanced
11
12 their clinical work and the ability to support their patient:
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17 *S5: you know she's around, ...even just catching up in the corridor you know if*
18
19 *something springs to mind that you know she's just met with somebody,for*
20
21 *example in the case with [Name] ... as soon as employment specialist knew that there*
22
23 *was something maybe going awry that she was able to quickly come to me, then we*
24
25 *could quickly look at 'ok how can we work through this, how can we work together*
26
27 *with this' ... so really that kind of collaborative working has been really positive.*
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33 Individualised job search: To ensure a good job match is achieved the search needs to be
34
35 based on client's preferences and needs rather than what jobs are available. This fidelity
36
37 criterion seems not to have been adhered to from the patient perspective, as they commented
38
39 that the IPS service did not meet their expectations which led to challenges in seeing the
40
41 potential benefits of the service. Two patients reported that their job search preferences were
42
43 discarded, and this had a negative impact on their engagement with the service:
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49 *P2: I felt like I was banging my head against a wall sometimes... I ended up applying*
50
51 *for stuff almost to please IPS, it's like when you're on jobseekers [welfare benefits] or*
52
53 *whatever and you have to apply to at least so many jobs a week and you apply to them*
54
55 *with like no hope or no real want to get that job because it doesn't suit you but you've*
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3 *got to tick these boxes and I was kind of doing that to some extent and then I just*
4
5 *burnt out.*
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10 *Job development – Frequent Employer Contact:* Each Employment Specialist should make at
11
12 least 6 face to face employer contacts per week on behalf of clients looking for work. Becker
13
14 and colleagues (2008) argue that although this is important for fidelity, Employment
15
16 Specialists may avoid this part of their job as they maybe nervous about contacting
17
18 employers, and although clients are encouraged to participate in the job search, employment
19
20 specialists should always offer to help if the client is struggling. This appears to be the case in
21
22 the below narrative:
23
24

25
26 *P1: I think the help was there, like employment specialist did do the CV for me but I*
27
28 *was looking at perhaps becoming a [Industry job role] and how to get into that and*
29
30 *employment specialist had limited knowledge on that subject... I don't expect her to*
31
32 *know everything but so then employment specialist said to me well go find some*
33
34 *companies that do that, whereas I expected the employment specialist to kind of find*
35
36 *companies that would do that.*
37
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42 *Job Development – Quality of Employer Contact:* This fidelity criterion which follows the
43
44 above, aims to learn the needs of the employer and to describe their client's strengths to
45
46 ensure a good match. For example, from an employer's perspective fears regarding offending
47
48 history, mental health, employability, and disclosure were reported. Although the
49
50 Employment Specialist provided support to the employers such as responding to concerns
51
52 regarding the patients' offending histories or mental health issues, it appeared that patients'
53
54 mental health issues were less of a concern for employers than their offending histories. In
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3 particular, the type of offence, and the type of employment they could offer were of
4
5 consideration:

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8 *E3: ...there's no way any kind of sex offence, no especially when you're dealing with*
9
10 *public and staff... if it was things like theft and fraud, when you're working in a retail*
11
12 *environment, that's something that you've.... I don't think I could.*

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16
17 **Disclosure:** Employment specialists provide clients with accurate information and assist with
18
19 evaluating their choices to make an informed decision regarding what is revealed to the
20
21 employer. The type of the offence and level of offence were a key consideration in the
22
23 employers' accounts. This was to the extent that if they had to decide to employ someone and
24
25 had the prior knowledge about the offence, they would not employ them in the first instance.
26
27 However, subjective ideas about the offence came into this, and different offences were
28
29 perceived to have different levels of acceptability.
30
31

32
33 *E1: ...To me, unless it's a serious offence then obviously that's different because you*
34
35 *know you're dealing with members of the public and children and that's ... a different*
36
37 *area for anybody.*

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41 *E3: I think with offending it would be, if it was things like theft and fraud, when*
42
43 *you're working in a retail environment, that's something that you've, I don't think I*
44
45 *could.*

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50 Clinical staff also discussed the type of offence that some of their patients had committed,
51
52 suggesting that it was of a level that would result in a barrier to employment.

53
54
55 **S10:** ... I suppose the main barrier would be about how it fits in with our particular
56
57 client group because the likelihood is that they have a conviction, that conviction is
58
59 likely to have been a violent offence which could prevent them having contact with
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3 *people that may be classed as vulnerable or being placed in certain situations that*
4
5 *might restrict what it is they could access from an employment perspective.*
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10 The support provided by the Employment Specialist was appreciated by patients:

11
12 *P1: ...she gave me the confidence to say it, like I ended up copping out and ended up*
13 *writing a note and like leaving it on my manger's desk.*
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19 When this fidelity criterion is reached and the employers were supported by the employment
20 specialist, and a good match made, employers were lenient, and supportive to the patient:
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22

23
24 *E2: He didn't sort of want to come in. I think he was having a few problems and then*
25 *he, what he did a few days later, he text me so I spoke to him I said 'well come try it*
26 *again' ...*
27
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29

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32
33 *E1: I think you've got to have a little bit of give and take with them, when they've got*
34 *anxiety problems and stuff, you know and because I knew..., I was bit more lenient*
35 *and you know he's doing ok yeah...*
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42 Due to these issues however, it was acknowledged by the employers that they could only
43 employ patients if they had the capacity to support them:
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46
47 *E5: ...comes down to budget and you know if you've got somebody that maybe is*
48 *going to be off because they have an issue, it's going to make it very difficult, not only*
49 *on us but everybody else in the store.*
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56 *Work Incentives Planning:* All clients should be offered an individualised work incentive
57 plan which includes effects of working on welfare benefits and if they begin work are
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3 assisted in reporting earnings, and making decisions regarding changing hours. This was
4
5 adhered to by the Employment Specialist:

6
7 *ES: ...so I tried to overcome that by obviously liaising with the Jobcentre to use their*
8
9 *benefits calculations to show to the patients that actually no you're not going to be*
10
11 *worse off you can actually be better off if you're doing a certain amount of hours and*
12
13 *so on.*
14
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19 However, although this service is provided via IPS, concerns about the impact of IPS on
20
21 patient entitlement to receive welfare benefits still featured in staff accounts:

22
23 *S: I think a lot of the problem that we have is people are worried about losing their*
24
25 *benefits... and that's the biggest stumbling block I found for nearly all of my patients.*
26
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30
31 In the literature, welfare benefits appear as both a structural barrier, i.e. regulations for social
32
33 insurance and employment, and an individual barrier, i.e. concerns about the impact of IPS on
34
35 their welfare benefits (Hasson et al., 2011).
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40 *Community Based Services:* IPS should be provided to clients in natural community based
41
42 settings as research has demonstrated that employment specialists who carry out their job
43
44 responsibilities away from their office help more people into employment. This was
45
46 appreciated by patients:
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48

49 *PI: I think one of the things is like helpful was that you were able to like, you were*
50
51 *quite flexible in when you were able to meet up,, I mean employment specialist*
52
53 *came out to the local [café] near me which is really great..*
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3 Furthermore, by moving the IPS into community settings, some bureaucratic barriers could
4 be avoided. For example, one staff member mentioned that NHS policies mean that only staff
5 can use the computers. This, they believed, prevented the employment specialist and patient
6 from collaborating on job searching and applications together.
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13 14 **Discussion**

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17 There is a dearth of studies that examined the barriers and facilitators for IPS implementation
18 in forensic settings. A study in the USA (Bond et al., 2015) reported that barriers to
19 employment were disengagement, current substance abuse, general medical problems, lack of
20 work skills, and criminal justice system problems. A UK based project that aimed to develop
21 an IPS programme for offenders with mental health problems identified further barriers,
22 including funding for additional employment support costs, such as criminal record checks,
23 uniforms, and travel to interviews (Samele et al., 2018). These authors identified flexibility
24 and a willingness to consider alternative options to employment, like volunteering and
25 education, as the key to successful implementation of IPS within forensic settings.
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40 Worthy of consideration are findings from studies conducted in general community mental
41 health settings. To an extent, our findings mirror those reported in a study of IPS
42 implementation in adult mental health settings in the UK which identified mental health
43 symptoms, effects of medication and previous illness record, and lack of work experience as
44 major barriers (Boycott et al., 2015). Other barriers cited included anxiety, lack of
45 confidence, and concerns regarding fitting in with colleagues (Boycott et al, 2015). Another
46 UK study, reported no statistically significant differences between IPS and traditional
47 vocational services for individuals with severe mental illness in the community (Howard et
48 al., 2010). However, this lack of difference was largely attributed to the reported suboptimal
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3 implementation of the IPS in terms of poor integration within mental health services, and
4 economic disincentives leading to lower levels of motivation in patients, and professionals.
5
6 This lack of engagement by services and professionals is underlined by a recent Swedish
7
8 study (Bergmarka et al., 2018) which identified lack of engagement from collaborating
9
10 partners, lack of interest in IPS among professionals, and challenges associated with
11
12 embedding IPS workers within services as barriers to implementation of IPS in community
13
14 settings.
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21 Furthermore, employers may have negative attitudes about employing those with offending
22
23 histories depending on the type of the offence they have committed, with about 70% of
24
25 employers in one study (Haslewood-Pocsik et al, 2008) being shown to be averse to
26
27 employing those with a conviction for arson or sex offences.
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33 Our study identified important barriers to IPS implementation including competing priorities
34
35 between IPS and psychological therapies and concerns among staff about the impact of IPS
36
37 on entitlement to welfare benefits. Offending history is as a key issue from employers'
38
39 perspective. One important barrier is that NHS policies mean that only staff can use the
40
41 computers. This can prevent the employment specialist and patient from collaborating on job
42
43 searching and applications together.
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49 Regardless of the proven benefits of employment for recidivism and mental health, another
50
51 barrier for IPS implementation was the staff perspective that their patient was not work ready.
52
53 Staff made the determination if the patient was ready for IPS, and held back referrals.
54
55 Therefore, there are power dynamics in deciding whether a patient is ready for employment.
56
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58 Further barriers to IPS were due to the subjective opinions regarding offending histories held
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3 by employers. Although these barriers were minimised by the support and information
4 provided by the Employment Specialist, they were still evident from the interviews.
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10 Facilitators to implementation included clear communication of the benefits of IPS, close
11 liaison with clinicians, and positive attitudes toward IPS among some clinicians and patients.
12 Patients cited enhancing their confidence and motivation to engage in purposeful activity as
13 the main benefits of IPS. Patients cited enhancing confidence as the main benefit of IPS.
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19 Additionally, the study helped raise the profile of the IPS model among stakeholders.
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24 The challenges associated with implementing IPS in forensic settings negatively impact IPS
25 fidelity which is known to account for some of the variance in outcomes in IPS studies.
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28 However, it is important to consider other factors such as professional skills (Drake et al.,
29 2006) particularly building a therapeutic relationship with the patient (Catty et al, 2008). The
30 development of IPS specifically for individuals with offending histories is an adaptation
31 suggested by some authors (Bond et al, 2015). IPS augmentation using motivational
32 strategies and developing IPS teams with expertise in working with offender groups have
33 been suggested to improve employment outcomes (Bond et al, 2015). However, the findings
34 of our study do not provide justification for making adaptations to the IPS model.
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46 The barriers identified in this study are not insurmountable. Future studies need to consider
47 enhancing staff training and intensifying IPS practices, for example, by providing peer
48 support and sharing more examples of people securing employment to address attitudes and
49 beliefs of clinicians, and ensuring a clear focus from clinical and employment staff on
50 helping a participant manage personal information which includes talking about offending
51 history. Furthermore, consideration of work readiness should be undertaken via a discussion
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3 between the employment specialist and the patient, rather than the current practice of clinical
4 staff overriding the patient's employment ambitions. Furthermore, when introducing an IPS
5 service there needs to be better information about how welfare benefit payments would be
6 affected if they considered IPS. Enhancing facilitators to IPS implementations is worthy of
7 consideration, for instance, through robust interdisciplinary collaboration, organisational
8 support and clear communication of the benefits of IPS to all stakeholders. Furthermore,
9 considerations need to be given to developing, or joining existing IPS learning collaboratives.
10 Learning collaboratives foster a culture of collaboration between IPS programmes through
11 the collection of data concerning programme implementation and outcomes, sharing of
12 knowledge, provision of training and technical support as well as research and innovation
13 (Becker et al., 2014; Margolies et al., 2015).
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33 ***Study strengths and weaknesses***

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35 This study provides unique insights into the challenges associated with implementation of
36 IPS in a community forensic setting, an area that has attracted little attention in the literature.
37 However, the study suffered a number of limitations, including that IPS was implemented on
38 a small scale and over a relatively short period of time as part of a clinical trial. A small
39 number of patients and employers agreed to take part in the study, and most of the employers
40 had no direct experience of the IPS model. Future studies should examine the barriers and
41 facilitators to IPS implementation in other forensic or criminal justice settings, using larger
42 samples. This would help form a better understanding of the barriers and facilitators to
43 implementation of IPS in these settings.
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Conclusion

Implementation of IPS in a community forensic setting is a complex process that requires robust planning and collaboration. The findings of this study show that the barriers and facilitators to implementing high-fidelity IPS in forensic settings are very similar to those encountered in community mental health settings, but that an offending history combined with a mental illness is an additional barrier. Practitioners and funders need to take this into account when implementing IPS programmes in community forensic settings. Deriving tangible benefits from an IPS service requires considerable investment on the part of health services as well as ongoing support from both clinicians and service managers. Besides, a considerable amount of work is required to engage potential employers, who are seemingly more flexible and sympathetic towards employing patients with mental health problems than those with offending histories. Additionally, further work is needed to develop an IPS learning collaborative in the UK to help understand and overcome the similar and unique barriers to IPS implementation in forensic settings. Implementation of high fidelity IPS services requires technical support to educate clinicians about the value of employment and how IPS differs from other forms employment support. Work with commissioners of healthcare is often needed to align contracts so they support the implementation of IPS practices. Finally, since the underpinning values of IPS are compatible with those of occupational therapy, for instance, in terms of the value of meaningful occupation and leading a productive life in the society (Auerbach, 2002), we argue that the findings of this study are potentially relevant to the clinical practice of occupational therapy.

Key findings

- Barriers to IPS implementation are competing interests between IPS and psychological therapies, and concerns about its impact on welfare benefits, and facilitators are interdisciplinary collaboration and organisational support.
- Patients cited enhancing confidence as the main benefit of IPS.
- Offending history is as a key issue from employers' perspective.

What the study has added

This study identified barriers and facilitators to IPS implementation in community forensic mental health settings. The findings can potentially help service provider implement and deliver high fidelity IPS programmes.

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Table 1: IPS Fidelity Scale scores at the end of implementation

	Domain	Fidelity Review Score
	<i>Staffing</i>	
1	Number on caseload	5
2	Employment Services Staff	5
3	Vocational Generalists	5
	<i>Organisation</i>	
4	Integration with CMHT through team assignment	5
5	Integration with CMHT through frequent contact	5
6	Collaboration between employment specialists and Job Centre Plus	5
7	Vocational unit	5
8	Role of employment supervisor	4
9	Zero exclusion criteria	3
10	Mental Health Agency focus on competitive employment	4
11	Executive Team support	4
	<i>Services</i>	
12	Work incentives planning	5
13	Disclosure	5
14	Ongoing, work-based vocational assessment	5
15	Rapid search for competitive job	4
16	Individualised job search	4
17	Job development – Frequent employer contact	5
18	Job development – Quality of employer contacts	4
19	Diversity of job types	0*
20	Diversity of employers	0*

21	Competitive jobs	0*
22	Individualised follow-along supports	0*
23	Time-unlimited follow-along supports	0*
24	Community-based services	0*
25	Assertive engagement and outreach by integrated team	3
	Total score	85
	Maximum IPS score	125

*not assessed due to lack of sufficient referrals at that stage.

For Peer Review