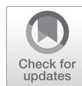

Supported Employment

Gary R. Bond and Kim T. Mueser

Introduction

Worldwide, many surveys show that most people with severe mental illnesses (SMI) such as schizophrenia and treatment refractory major mood disorders want to work (Bond et al. 2020a) but only a small fraction are employed at any time after their initial diagnosis – for example, less than 15% of people with schizophrenia (Hakulinen et al. 2020). For most people with SMI, employment is a goal because working is a normal adult role and it provides meaning, social contact, community integration, self-esteem, increased income, and better quality of life (Luciano et al. 2014; Modini et al. 2016a). Moreover, more than two-thirds of people with SMI live in poverty (Draine et al. 2002). Employment income can help reduce this source of misery.

People with SMI are often demoralized but fearful about the consequences of working. Yet most yearn to lead normal lives, to be part of general society, and to be productive (Maslow 1970). A job is a place where you are *needed*; if no one depends on you showing up, then why even bother getting up in the morning? (Beard et al. 1982).

Among the many different vocational approaches described in the literature, few have been adequately described, and, until the turn of the century, none had a systematic body of rigorous research showing effectiveness in increasing competitive employment rates (Bond 1992; Bond et al. 1999; Lehman 1995). Vocational approaches that enjoyed widespread adoption include various skills training approaches (Wallace et al. 1999), the clubhouse model (McKay et al. 2018), the job club (Corrigan et al. 1995), and the Boston University choose-get-keep model (Rogers et al. 2006). More recently, customized employment has gained popularity as a promising approach (Riesen et al. 2015). However, in most cases these approaches have not been systematically studied using randomized controlled trials; among those that have been subjected to rigorous research, the findings have been disappointing or lacking replication. In this chapter we describe individual placement and support (IPS), the one program that has demonstrated effectiveness in helping clients with SMI gain competitive employment.

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Principles of Individual Placement and Support

IPS is a well-defined model of supported employment for people with SMI. It was first described in a manual in 1993 (Becker and Drake 1993) and further delineated a decade later (Becker and Drake 2003). IPS is defined by a core set of principles: zero exclusion criteria, focus on competitive employment, integration of vocational and clinical services, individualized benefits counseling, attention to client preferences, rapid job search, targeted job development, and provision of long-term follow-along supports. These principles are all supported by empirical research (Drake et al. 2012). IPS researchers have developed a fidelity scale, called the IPS-25, to measure adherence to IPS principles (Bond et al. 2012b). Numerous studies have documented that the IPS-25 is psychometrically sound, and state and local mental health administrators and IPS team leaders frequently use it as a quality improvement tool in routine practice.

Zero Exclusion Criteria

Neither clinicians nor researchers can accurately predict which persons with SMI can obtain competitive work (Anthony and Jansen 1984). Therefore, not excluding any client who wants to work improves the likelihood that IPS will be available to the greatest number of clients who may potentially benefit from it. For clients with SMI, the only criterion for admission to an IPS program is the expressed desire to work in a competitive job. Thus, IPS programs do not use the many criteria that traditional vocational programs use to exclude clients, such as substance abuse, clinical instability, medication nonadherence, cognitive impairment, or time since the most recent hospitalization.

Focus on Competitive Work

Most people with SMI specifically seek to work competitive jobs, defined as regular jobs in community settings paying at least minimum wage and not set aside for people with disabilities (Bond and Drake 2014). IPS honors this preference by focusing only on competitive work, in contrast to other vocational approaches, which may emphasize sheltered work as a stepping-stone to competitive work, or transitional employment, in which individuals work at jobs in the community that have been secured by the agency providing the vocational services and are owned by that agency, in order to develop their work experience and resumés before moving onto competitive jobs. Thus, unlike traditional vocational approaches that followed a "train-place" model in which clients receive training before placement into a competitive job, IPS follows the "place-train" approach in which consumers receive any necessary training following attainment of a competitive job (Wehman and Moon 1988). When on-the-job training is needed, it is most often provided by the employer, but it can also be provided by the IPS specialist, whereas any training conducted off the job site is given by the IPS specialist. In practice, people with serious mental illness typically receive little formal on-the-job coaching from IPS specialists.

Integration of Vocational and Clinical Services

Clients enrolled in vocational services benefit more if they also receive appropriate mental health treatment services (Cook et al. 2005). As first documented in a pioneering work by Stein and Test (1980), treatment and rehabilitation programs are most effective when practitioners addressing different aspects of a client's treatment plan collaborate closely. This holds true for vocational services, for several reasons (Drake et al. 2003): First, the integration of IPS with mental health treatment maximizes the chances that the client's clinical treatment providers will support the client in pursuing his or her vocational goals. Second, issues pertinent to the clinical management of the client's psychiatric disorder may become apparent to the IPS specialist in the process of working with the individual

(e.g., medication side effects, disruptive or distressing symptoms), and communicating these problems to the treatment team may lead to effective solutions that both address the clinical problems and increase the client's ability to work. Third, clinicians involved in the treatment of the client's psychiatric disorder may have valuable suggestions for job leads. Fourth, clinicians may help address problems that interfere with work, such as inadequate coping, relapses, substance abuse, and limited interpersonal skills by providing these treatments directly or referring clients to appropriate services. For example, cognitive behavioral therapy for psychosis (Kukla et al. 2020), integrated treatment for co-occurring substance use disorders (Becker et al. 2005), and teaching illness self-management skills (Gingerich and Mueser 2010, 2011) are evidence-based practices that can be effective at addressing these problems.

The integration of vocational and clinical services occurs most effectively when the IPS specialist collaborates closely with the client's clinical treatment team, attending weekly team meetings and interacting frequently with the client's case manager and other clinicians. Integration is most easily attained when the IPS program and the clinical treatment team are located within the same agency and ideally have offices in close proximity to each other. IPS programs typically collaborate with multiple mental health treatment teams. In order to foster strongly working relationships, it is preferable for each IPS specialist's caseload to be limited to one or two treatment teams. Unlike in the assertive community model, however, the IPS specialist is usually not a formal member of a specific treatment team.

Benefits Counseling

People with SMI have often suffered a long and arduous process of applying for and obtaining disability benefits. After this struggle to obtain benefits, it is understandable that many clients are concerned about the effects of work on their benefits (Livermore and Bardos 2017). Benefits counseling is aimed at helping clients understand the impact of returning to work on their benefits, including how much they can work before experiencing a reduction in their financial benefits and the potential loss of their health insurance. Clients with psychiatric disabilities who receive personalized counseling on the impact of earnings on their benefits accrue more earnings from employment (Tremblay et al. 2006).

Client Preferences

Respect for individual client preferences is an important defining characteristic of supported employment. Client preferences for the type of work desired can inform the job search. Research shows that clients who obtain jobs that match the expressed interests have significantly longer job tenures than clients who obtain jobs outside of their areas of interest (Becker et al. 1996; Mueser et al. 2001). Client preferences also have a significant bearing on the type of supports provided by the IPS specialist. Typically half or more of clients opt to disclose their psychiatric disability to a prospective employer (DeTore et al. 2019; Jones and Bond 2007), thereby enabling IPS specialists to play an active role in helping them obtain the job and keep it through direct contacts with the employer. For example, IPS specialists can join discussions with the employer to help clients negotiate any needed reasonable accommodations, as protected by the Americans with Disabilities Act. Other clients prefer not to disclose their psychiatric disability, in which case the IPS specialist plays a "behind-the-scenes" role in helping the client achieve his or her employment goals.

Targeted Job Development

To help clients find jobs matching their preferences, IPS specialists must network with employers. The job-finding process takes several forms: sometimes clients meet employers alone with the IPS specialist coaching behind the scenes; other times the IPS specialist and client together have

an introductory meeting with a prospective employer. The job match is often made through individualized job searches but can also draw on a pool of prospective employers that IPS specialists are continuously building. The process of contacting employers and cultivating relationships is called job development. It entails IPS specialists who make multiple contacts with individual employers over a period of time, usually well before any client makes contact. The IPS job development approach is inspired by the metaphor of "three cups of tea" ("The first time you share tea with a stranger, you are a stranger. The second time you take tea, you are an honored guest. The third time you share a cup of tea, you become family.") (Mortenson and Relin 2006). Through this process, IPS specialists are successful in finding (or creating) jobs openings (Carlson et al. 2018). Job development increases the likelihood of obtaining competitive employment (Leff et al. 2005).

Rapid Job Search

The process of helping clients find a job begins soon after a client enrolls in an IPS program, with the first face-to-face employer contacts usually occurring within 1 month. This is in contrast to other vocational approaches, which may require prevocational skills training and/or extensive workplace assessments that involve extensive periods of time to complete. Research suggests that when clients receive prevocational preparation prior to beginning a job search, they often become habituated to prevocational settings and never seek competitive employment; they also tend to lose interest and drop out of vocational services (Bond 2004). Therefore, rapid job search is one of the most defining characteristics of IPS.

Follow-Along Supports

Historically, vocational rehabilitation was deemed successful when a client obtained competitive employment and remained in that job for a period of a few months, at which point funding and follow-along support were discontinued. In contrast, IPS continues to provide follow-along supports without a predetermined time period. IPS specialists provide a wide variety of follow-along supports. These include helping the client learn job-related tasks, providing on-site or off-site support to the client, negotiating reasonable accommodations with an employer, and facilitating the transition to new job responsibilities, or, if a client loses a job, helping them find a new job. Provision of follow-along supports for a year or more after a client obtains a job is associated with longer job tenure (Bond and Kukla 2011). Some research suggests that face-to-face contact is more strongly associated with job tenure (Bond and Kukla 2011), though more recent research suggests promising new approaches to long-term support through videoconferencing, texting, and other forms of telehealth (Drake 2020a).

Other Features of IPS Programs

In addition to the principles described above that guide the provision of IPS, several key features distinguish IPS from other approaches to vocational rehabilitation. Work is a normalizing activity that takes place in the community, and therefore most IPS services are provided in the community rather than the mental health center or rehabilitation agency. IPS specialists meet with clients in settings that are convenient and comfortable for them and often spend time together walking around the community, exploring possible jobs, and talking to prospective employers.

IPS is also recovery-oriented and strengths-based. The consumer movement has argued successfully for a redefinition of recovery that is not based on the absence of psychopathology (as in traditional medical definitions) but rather defined in terms of individual consumers' hopes and dreams (Jaiswal et al. 2020). Thus, recovery has been defined as "the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony 1993). Another definition of recovery is "the process in which people are able to live,

work, learn, and participate fully in their communities" (New Freedom Commission on Mental Health 2003). As work is a common personal recovery goal for many clients (Provencher et al. 2002), the emphasis in IPS on community-based services, competitive employment, zero eligibility exclusion criteria, and respect for client self-determination is all compatible with the philosophy of recovery.

Also consistent with recovery is the emphasis in IPS on client strengths rather than deficits and viewing the community as a potential resource rather than a barrier to the client's employment goals (Rapp and Goscha 2011). The identification of client strengths plays an important role in building up clients' self-confidence and helping them sell themselves to prospective employers. IPS specialists are always on the lookout to engage natural supports for the client in the community, including both in the workplace (e.g., supervisor, coworkers) and at home (e.g., family or friends), in addition to the client's treatment team. Capitalizing on natural supports in the client's environment takes advantage of the spontaneous opportunities these individuals may have to help the client, often at times when the IPS specialist cannot be available, thereby avoiding unnecessary dependence on the IPS specialist for providing all the needed supports.

Although IPS specialists provide a full range of vocational services, such as job development and follow-along supports, they often may be involved in helping clients manage their psychiatric disorder more effectively and improving their interpersonal skills. For example, cognitive difficulties may make it difficult for some clients to achieve their vocational goals (McGurk and Mueser 2004), and IPS specialists are often actively involved in helping clients use coping strategies for managing or minimizing their cognitive difficulties (McGurk and Mueser 2006).

The Organization of IPS Services

Except in very rural areas, IPS programs usually consist of a team staffed by at least one part-time team leader and two full-time IPS specialists. To remain grounded in the everyday realities of helping clients find and keep jobs, the IPS team leader carries a reduced caseload of clients. The team leader provides weekly supervision to the IPS specialists and serves as a liaison for the program or other teams and programs, both within the agency and at other agencies. IPS specialists focus exclusively on providing vocational services; they do not have clinical responsibilities, such as case management, leading skills training groups, or providing psychotherapy. This clear delineation of job duties ensures that IPS specialists need not decide whether to provide vocational services or some other service to clients on their caseload.

In addition, every IPS specialist provides the full range of vocational services for each client, as described above (e.g., assessments, job development, and provision of follow-along supports). This is in contrast to the division of labor found in some vocational programs in which services such as job development and follow-along supports are provided by different individuals. By ensuring that a single practitioner provides the entire range of vocational services, IPS programs avoid requiring clients to develop relationships with multiple vocational service providers as they progress through the employment process. By having all IPS specialists involved in job development rather than just one or two specialists, the team is able collectively to identify a much broader range of jobs. While job development is primarily aimed at finding a job matched for a specific client, IPS specialists also identify jobs that may not be suitable for the jobseeker for which the search was intended but which can be shared with other IPS specialists to the benefit of other clients in the program.

Research on the Effectiveness of Supported Employment

Numerous reviews conclude that IPS is effective in helping clients achieve competitive employment (Brinchmann et al. 2020; Frederick and VanderWeele 2019; Modini et al. 2016b). The IPS evidence base includes quasi-experimental

studies examining conversion of day treatment services to IPS (Bond 2004) and randomized controlled trials (RCTs) of well-implemented IPS programs (Bond et al. 2020a). Since RCTs are the gold standard in evaluating the effectiveness of an intervention, we will focus primarily on this body of research. We also briefly summarize the findings from four long-term follow-up studies.

Randomized Controlled Trials

The most recent compilation of RCTs of IPS for people with serious mental illness identified 28 studies (including 7 multisite studies) with a total of 3187 IPS clients and 3281 control clients (Bond et al. 2020a). Although the initial studies were conducted in the USA, increasingly other countries have also conducted RCTs of IPS. These RCTs included 12 conducted in the USA and 16 conducted in 12 countries outside the USA. Study sites ranged widely geographically and included mostly large and midsized cities and a few rural communities. Most studies recruited unemployed clients receiving services from a community mental health center, though some studies enrolled other target groups (e.g., young adults with early psychosis, disability beneficiaries, and veterans with posttraumatic stress disorder). The control groups were usually offered services as usual (whatever vocational rehabilitation services were available in the community), but in some studies the control group received well-regarded vocational programs that followed a different service model, typically a train-place model or, in some cases, multiple vocational models. (For the list of studies and more methodological details, go to *Evidence for IPS* at https://ipsworks.org/index.php/library/.)

In 60% of the studies, the follow-up period was 18 months or longer. All 28 RCTs found that employment outcomes significantly favored IPS, usually with large differences. Averaging across studies, 55% of IPS participants worked in a competitive job during follow-up, compared to 25% of control participants. The findings from the USA generalize well outside the USA: RCTs in 11 countries and 4 continents have found that IPS participants had significantly better competitive employment outcomes than control participants. The IPS competitive employment rate in these RCTs is similar in North America, Asia, and Australia, though somewhat lower in Europe (Drake et al. 2019).

Controlled trials of IPS consistently show its effectiveness across a wide range of employment outcomes. For example, one meta-analysis combining results from four RCTs found that, compared to control participants, IPS participants gained employment faster, maintained employment four times longer during follow-up, earned three times the amount from employment, and were three times as likely to work 20 hours or more per week (Bond et al. 2012a).

Long-Term Outcome Studies

Long-term follow-up studies are important for assessing the permanence of the impact of an intervention. In IPS studies, the general standard is to measure the percentage of the sample who are “steady workers” (employed at least 50% of the follow-up period). In a 10-year follow-up study of IPS, 86% of former IPS clients reported working during follow-up and 33% were steady workers (Salyers et al. 2004). In a second study, 100% had worked at some time during follow-up 8–12 years after enrollment, and 71% were steady workers (Becker et al. 2007). A Swiss RCT examined outcomes 5 years after enrollment and found that the percentage of steady workers was much higher for IPS than for the control group (44% versus 11%) (Hoffmann et al. 2014). A follow-up study of a large, multisite trial examined earned income reported to the Internal Revenue Service and found significantly higher annual earnings for IPS clients compared to controls which persisted over a 5-year period after the initial 2-year follow-up study had ended (Baller et al. 2020).

The implications of this research are especially significant in light of two general findings. First, as noted earlier, the competitive employment rate for individuals with SMI in the public

mental health system is 15% or less. Therefore, a steady employment rate of 50% or more in this population is far above the norm. Second, these findings are in stark contrast to the attenuation effects found for many psychosocial interventions once the active intervention has been discontinued (e.g., Stein and Test 1980). Once IPS clients begin working, the natural reinforcers of work (a paycheck, making a meaningful contribution to society, social connectedness) may provide incentives to continuing to work. In any case, the "yo-yo effect" of diminishing gains following treatment cessation for weight loss and exercise programs has not been found for IPS. These findings suggest that IPS promotes a life trajectory that differs from that of patienthood and dependence.

Growth of IPS

The effectiveness of IPS has been well established for two decades. Throughout the USA, state leaders show great interest in implementing IPS, and many states now offer IPS services statewide. According to a 2019 telephone survey of state mental health and vocational rehabilitation (VR) leaders, 80% of states in the USA have implemented IPS services, with over 850 IPS programs nationwide (Pogue et al., 2022). Yet the total number of people receiving IPS is only a fraction of the total population of unemployed Americans with serious mental illness. Clearly, the key question is no longer whether IPS works, but rather, as for other evidence-based psychosocial practices, how to close the gap between the known population of those who want and need these evidence-based services and those who have access. According to over a dozen surveys, 60% of people with serious mental illness want to work (https://ipsworks.org/index.php/evidence-for-ips/), but only about 2% have access to IPS (Bruns et al. 2016).

The paramount obstacles to adequate access to IPS include the failure of policymakers to understand the connection between work and general health and the lack of political will. Government leaders often do not recognize that employment is a critical mental health intervention (Drake and Wallach 2020). At the practical level, the primary barriers have been inadequate funding and the lack of an evidence-based methodology for widescale expansion (Drake et al. 2016). Inadequate funding for employment services is a worldwide problem, though some countries, such as England and the Netherlands, have made national commitments to fund IPS access (Becker and Bond 2020). The second ingredient is a strategy to facilitate adoption, high-fidelity implementation, and sustainment of IPS. One strategy that has borne fruit is a "learning community." Since 2002, the IPS Employment Center has led an international learning community that coordinates education, training, technical assistance, fidelity and outcome monitoring, and regular communications through newsletters, bimonthly calls, and an annual meeting (Drake et al. 2020a).

In the USA, IPS programs participating in the learning community continuously monitor employment rates and report them to the IPS Employment Center every 3 months, a process that has been maintained over 18 years. The quarterly employment rate for the US states in the learning community has not declined below 40%, even during the Great Recession of 2007–2009 and during the COVID pandemic (as of October 2020). The learning community has facilitated sustainment of IPS services over time: one prospective study found that 96% of 129 IPS programs were sustained over 2 years (Bond et al. 2016). The number of IPS programs has expanded steadily, with a mean annual growth rate of 26% in the number of IPS programs in the USA. The learning community has helped to initiate and maintain over 450 IPS programs, including 366 in the USA and 100 outside the USA, most at high fidelity with good employment outcomes (Drake and Wallach 2020).

While the learning community has had a catalytic effect on IPS expansion, another mechanism that has independently (and in some case synergistically) promoted the spread of IPS in the USA has been class action lawsuits. In 2009, the US Department of Justice began to enforce the Supreme Court's decision in *Olmstead v. L.C.*,

requiring states to ensure that persons with disabilities should have the opportunity to live like people without disabilities and to receive services in the most integrated setting appropriate to their needs (Burnim 2015). As part of furthering community integration, Olmstead settlements in numerous states have included the mandated expansion of supported employment services for people with serious mental illness. These class-action lawsuits have promoted IPS services in a dozen states over the last decade, some with considerable success (Bond et al. 2021; Johnson-Kwochka et al. 2017).

IPS has expanded worldwide, with IPS programs in 19 countries (Australia, Belgium, Canada, China, Czech Republic, Denmark, France, Germany, Iceland, Ireland, Italy, Japan, New Zealand, the Netherlands, Norway, Spain, Sweden, Switzerland, and the UK) (Drake 2020b). Factors that have promoted its international growth include unique features of the IPS model that make its adoption attractive and its implementation feasible, local champions, local research studies demonstrating the effectiveness of IPS, the development of technical assistance centers, and national initiatives (Bond et al. 2020b).

Costs of IPS

Several studies have estimated an average annual cost of IPS of approximately 5000–8000 USD per client, though these estimates vary widely depending on estimation methods, assumptions, and caseload size (Salkever 2013). Cost-benefit and cost-effectiveness analyses of IPS are rare. The most rigorous IPS cost-benefit analysis was a large multinational randomized controlled trial in Europe, which concluded that IPS yielded better employment and health outcomes than alternative vocational services at lower cost overall to the health and social care systems. The major cost savings were in reduced hospitalizations for IPS (Knapp et al. 2013). A 5-year follow-up RCT of IPS reported substantially greater return on investment for IPS compared to usual vocational services ($0.54 vs. $0.18 per dollar invested) (Hoffmann et al. 2014). A recent cost-effectiveness study of IPS has found that IPS was less costly and more effective than services as usual (Christensen et al. 2021). An early study found that service agencies converting their day treatment programs to IPS reduced service costs by 29% (Clark 1998). A promising area for cost savings concerns young adults who are experiencing early psychosis. If IPS can help young adults gain steady employment and thereby avert or at least delay entry into the disability system, the savings would be enormous (Drake et al. 2020b). One Norwegian study suggests that such a strategy may be viable (Sveinsdottir et al. 2020).

Conclusions and Future Directions

Abundant research shows that the IPS is effective at improving employment outcomes for persons with SMI. In addition to the clinical efficacy of the IPS model, research has demonstrated that IPS can be implemented and sustained in routine community settings. Furthermore, economic analyses suggest that IPS can be implemented and sustained as relatively modest cost (compared to many mental health services) and that the costs of IPS may be potentially offset by decreases in the use of other mental health services.

The success of the IPS model has led to several other avenues of research, including efforts to identify ancillary services designed to target client characteristics thought to interfere with achieving positive vocational outcomes. One fruitful area has been augmenting IPS with cognitive remediation for people with impaired cognitive functioning or who do not respond to standard IPS (McGurk et al. 2007, 2015). Another important area of research concerns the impact of IPS on young adults with mental health conditions, especially young adults with a first episode of psychosis (Bond et al. 2015). As the early onset of psychosis often curtails individuals' educational attainment (Kessler et al. 1995), which has negative repercussions in the labor market, there has been a growing interest in

supported education, or helping clients achieve educational goals such as receiving a high school diploma, pursuing an associate's or bachelor's degree, or completing a certificate program (Manthey et al. 2012). The principles of supported education parallel those for IPS (Bond et al. 2019; Swanson et al. 2017). Many IPS programs, especially those serving young adults, now integrate supported employment with supported education. Coordinated specialty care programs for first episode psychosis (Heinssen et al. 2014) often include an intervention that provides both supported employment and education, depending on the client's goals (Nuechterlein et al. 2020; Rosenheck et al. 2017). However, the impact of supported education, or programs that provide both supported employment and education, on educational outcomes has not yet been convincingly demonstrated in randomized controlled trials, and at present it cannot be considered an evidence-based practice (Ringelsen et al. 2017). More work is needed to address the impact of IPS on the first episode psychosis population and to establish standardized guidelines for providing supported education.

The rehabilitation field has made important strides in improving employment outcomes for people with SMI over the past two decades. The IPS model of supported employment is an evidence-based practice for vocational rehabilitation. An important priority is to increase the access of persons with SMI to IPS programs, which have the potential to enhance quality of life by improving the economic standing of clients, giving them something meaningful and rewarding to do with their time, and promoting their integration into their communities.

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