Extending Individual Placement and Support (IPS) to Underserved Populations

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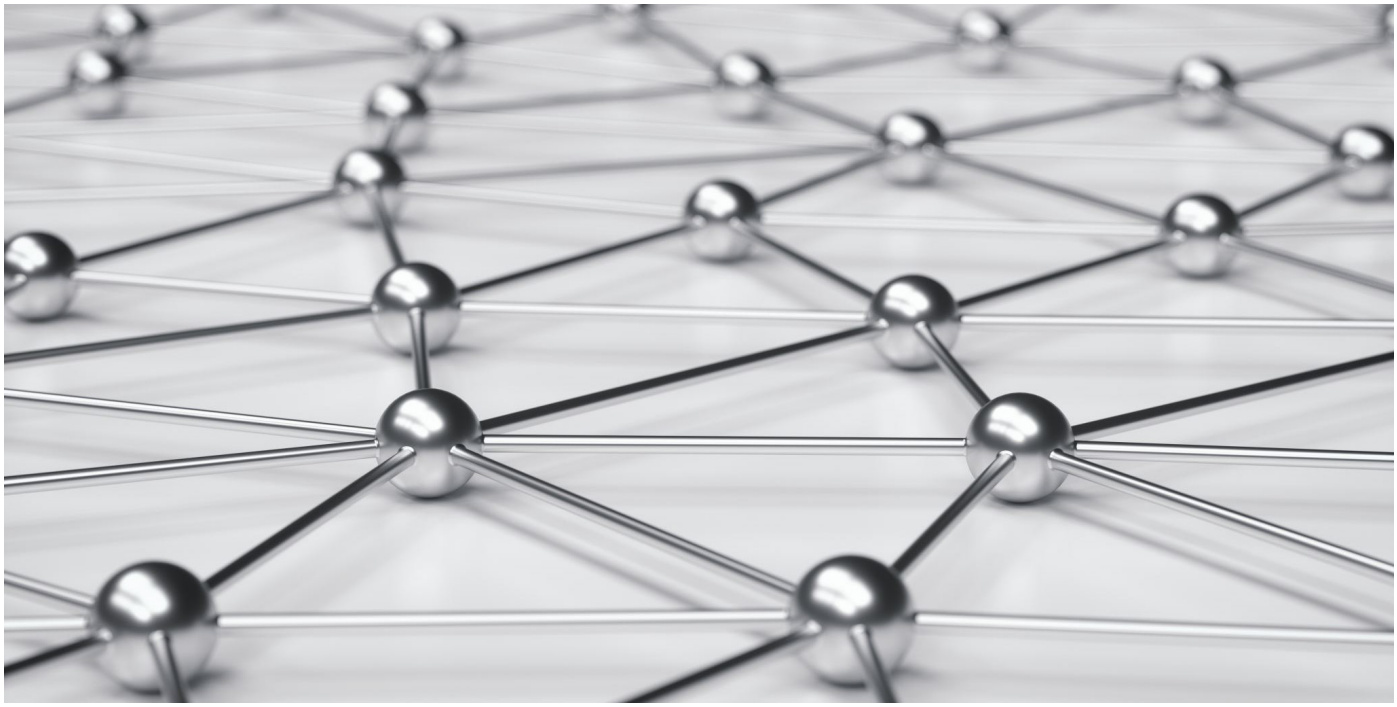

Extending Individual Placement and Support (IPS) to Underserved Populations

Supported Employment: A Critical Mental Health Intervention

Employment facilitates positive mental health – in the form of increased self-esteem, self-confidence, quality of relationships and lifestyle, and symptom control – as well as improvements in income, housing, and social support.[1-7] Conversely, unemployment contributes to anxiety, depression, increased alcohol and drug use, family difficulties, and social isolation.[8-11] Mental health professionals and researchers worldwide now recognize that competitive integrated employment (CIE) improves the quality of life for people with mental health conditions because it leads to increased psychological health and decreased use of crisis and institutional services.[12] Research on the Individual Placement and Support (IPS) model of supported employment confirms this critical observation. Over the past three decades, numerous studies, including more than 30 randomized controlled trials in the U.S. and other countries, have established the efficacy of IPS as an evidence-based practice enabling people with a broad range of mental health conditions to achieve CIE.[13-15]

IPS emphasizes eight basic principles, each supported by research:

1) **Focus on CIE:** IPS programs help clients obtain regular jobs in the community
2) **Zero exclusion**: every client who wants to work is eligible for services regardless of barriers
3) **Attention to client preferences**: services follow clients' choices, rather than practitioners' judgments
4) **Rapid job search:** IPS specialists help clients look for jobs soon after they express interest, rather than providing lengthy pre-employment preparation
5) **Targeted job development:** based on clients' interests, IPS specialists build relationships with employers through repeated contact
6) **Integration of employment services with mental health treatment:** IPS programs

collaborate closely with mental health treatment teams

7) **Personalized benefits counseling:** IPS specialists help clients obtain tailored, understandable, and accurate information about how working may impact their benefits
8) **Individualized long-term support:** follow-along supports, tailored for the individual, continue for as long as the client wants and needs them

Purpose of this Issue Brief

This issue brief identifies subgroups of people with mental health conditions who do not use the public mental health system but need supported employment services. The brief estimates their prevalence and illustrates how adaptations to IPS can help these groups. The authors sometimes identify relevant groups by diagnosis (e.g., "people with substance use disorders") or by program location (e.g., "people in Federally Qualified Health Centers"), recognizing that some people may belong to more than one group and/or participate in multiple programs. The following sections do not aim to be comprehensive. Instead, they represent examples of extending IPS to new groups, supplementing previous research on these populations.[16-17] The authors omit groups in areas with no known IPS outreach or groups without available data, such as individuals receiving services from a private mental health provider, or in community colleges, community cultural programs, religious organizations, and American Indian/Native American reservations.

The Need for IPS Supported Employment

IPS has spread steadily over the past two decades in at least 43 states, in the District of Columbia, throughout the Veterans Health Administration (VHA) system, and in approximately 25-30 other countries. In virtually every setting, IPS providers began by serving people with serious mental illness (SMI) in community mental health centers, the original target group with robust research evidence.[15] Although the term "serious mental illness" denotes long-term disabling mental health conditions, no consistent definition of SMI exists.[18] Instead, epidemiologists and government agencies use varied definitions and measures with different limitations. As one common example, the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey of Drug Use and Health Survey estimates that approximately six percent of adults ages 18 and older (15.4 million people) have SMI.[19] However, this survey uses a particular definition that likely underestimates the prevalence of SMI by excluding people experiencing homelessness and who do not use shelters, military personnel on active duty, and individuals in institutions, such as jails, prisons, and hospitals.

According to SAMHSA's 2022 Mental Health National Outcome Measures (NOMs), 62,679 clients received IPS in the 43 reporting states, which is 1.7 percent of the population of eligible clients in the public mental health system who may benefit from these services.[20] This level of IPS utilization is grossly insufficient to adequately address disparities in employment outcomes for people with mental health conditions.

Over the last decade, mental health, addiction, housing, general medical, and other programs have started to extend IPS services to new populations, including individuals with SMI who do not participate in the public mental health system and individuals with a wide range of other mental health conditions that may lead to unemployment.[21] For example, various programs now provide IPS to individuals with anxiety, depression, substance use disorder, post-traumatic stress disorder, and obsessive-compulsive disorder, among other mental health conditions. IPS research has been studied with some but not all of these groups.[13] Because other vocational approaches have little or no evidence base and may be ineffective, vocational rehabilitation leaders have identified IPS as a preferred approach because of its expanding evidence base.

Many adults who need supported employment cannot access IPS services. In the U.S., community mental health centers, comprehensive rehabilitation centers, and VHA settings house the majority of IPS programs.[21] However, many people with a mental health condition do not participate in either the state-federal vocational

rehabilitation system,[22] nor the public mental health system,[23] which includes state psychiatric hospitals, community mental health centers, certified community behavioral health centers, hospital and outpatient services provided by the VHA, and other programs. Some individuals do not qualify for these services because states often restrict mental health services to specific public assistance recipients or to people with specific mental health diagnoses. Many unemployed adults with a mental health condition belong to underserved, disadvantaged groups. Of critical importance, members of historically underserved groups such as Black or African Americans, Hispanic or Latino Americans, and American Indian/Native Americans, whose mental health and employment needs have been neglected or insufficiently addressed for decades, often receive no mental health services. SAMHSA's annual survey has continued to document higher past year mental health service use for White adults (16.6 percent) than for Black or African American adults (8.6 percent) and Hispanic or Latino adults (7.3 percent).[24] A national survey by the National Council for Mental Health Wellbeing examining access to mental health services found that 43 percent of Americans needing mental health care during 2022 did not receive this care. A majority of survey respondents agreed that a major barrier to access was finding a provider trained to understand cultural issues related to race, ethnicity, sexual orientation, or sociocultural status.[25]

Adults in Substance Use Disorder Treatment Programs

In 2020, the National Survey on Drug Use and Health found that 24.4 percent of transition-age youth (defined in the study as ages 18-25) and 14.0 percent of adults older than 25 had a substance use disorder.[26] Because the survey data largely omits people who are incarcerated, experiencing homelessness, or living in institutions, the true prevalence is likely higher. At least half of individuals with a substance use disorder also have a diagnosed mental health condition – and probably many more have an undiagnosed mental health condition.[26] People with a substance use disorder are more likely to be unemployed or not looking for work.[26] Moreover, Centers for Disease Control and Prevention (CDC) surveys show that the prevalence of substance use disorder and mental health conditions increased substantially during the COVID-19 pandemic.[27,28]

Historically, few people with substance use disorders have received IPS supported employment, primarily because substance use disorder treatment programs rarely provide employment services. The major exception has been people with a mental health condition and co-occurring substance use disorder who have had access to employment services through public mental health programs – a group that clearly benefits from IPS services.[29] However, a few substance use disorder treatment programs now use IPS. Some states use block grants, opioid relief funds, infrastructure grants, and Medicaid options (i.e., waivers and state plans) to extend IPS services to substance use disorder treatment programs. In addition, in 2022 the VHA committed to providing IPS to veterans with substance use disorders.

Recent research supports IPS for this population. The United Kingdom's National Health Service (NHS) recently completed an uncontrolled pilot study of IPS services for more than 600 clients with substance use disorders, showing that 36 percent started a job, and 38 percent of those who attained work remained employed for at least 13 weeks.[30] Further, 73 percent of clients reported improved health outcomes. A recently completed randomized controlled trial in seven substance use disorder treatment programs found significantly better CIE rates for IPS participants compared to individuals who used usual vocational services (30 percent versus 25 percent).[31] Given the evidence, the NHS plans to fund several dozen additional IPS programs in substance use disorder treatment centers across the country. In the U.S., a small randomized controlled trial within a methadone clinic for people with opioid use disorder in Oregon found that providing IPS dramatically increased CIE compared to usual services (50 percent vs. 5 percent).[32] Recently, the Building Evidence on Employment Strategies program initiated a randomized controlled trial using IPS services within substance use disorder

treatment programs.[33] A similar study is underway in Norway.[34]

Several IPS studies have identified adaptations to the IPS model for people in substance use disorder treatment programs.[35-37] These include increased attention to relapses and triggers of relapses, education regarding job interviews and pre-employment drug screening tests, and helping clients focus on jobs and job sites that limit exposure to alcohol or drugs. Because having money is a common trigger for relapse, new employees should also have a financial management plan before they receive a paycheck. Substance use disorder treatment programs face a major challenge in changing the traditional treatment culture from an exclusive focus on abstinence to recognition that employment is often part of clients' recovery strategy. Another adaptation involves working more actively with employers. To that end, many businesses now participate in the national Recovery-Friendly Workplace Community of Practice led by the White House Office of National Drug Control Policy.[38]

Adults in the Justice System

The justice system oversees a vast population of approximately 6.6 million people, including many with a mental health condition who face substantial obstacles to employment upon release from incarceration. In 2020, more than 2.2 million adults were incarcerated in federal (226,000), state (1,300,000), and local prisons and jails (631,000).[39] Upon release, those attempting reentry into the community face multiple barriers, including poverty, mental health conditions, substance use disorder, stigma, lack of housing, and a lack of life and social skills.[40,41] Nearly two in three individuals will return to prison within three years, and four in five individuals with prior justice system involvement in state prisons will return within five years.[42,43] Employment, especially stable, long-term employment,[44] enhances successful reentry after incarceration[45] and enables some to avoid recidivism. The justice system also supervises a range of people in the community in diversion, probation, parole, and other monitoring programs. In 2018, 4.4 million adults in the U.S. were on probation or parole.[46]

Individuals involved in the justice system often want to work, as indicated by high rates of employment-seeking activities.[47] But they face personal, social, environmental, legal, and structural barriers to employment. Individuals with a mental health condition are overrepresented at all stages of the criminal justice system[48,49] and are at high risk for repeat arrests and cycles of incarceration.[50] Employment is a key protective factor against such recidivism and an integral part of community integration and stability. Yet, those with a mental health condition and justice involvement face major barriers to stable, gainful employment.[51] Legal restrictions, which vary by state, often add barriers. In one large study, more than 60 percent of employers reported they would "probably not" or "definitely not" hire applicants with criminal justice records.[52] Structural barriers include living in low-income neighborhoods with few jobs, labor market discrimination, lack of affordable childcare, and legal sanctions, such as suspension of driver's licenses. Moreover, individuals leaving incarceration are disproportionately Black and Hispanic, for whom structural racism compounds other barriers.[53]

Limited evidence suggests that IPS may be effective for people with a mental health condition and criminal justice system involvement to find and maintain CIE.[35,54,55] Two randomized controlled trials of veterans with justice system involvement showed that IPS participants were nearly twice as likely to secure CIE compared to participants who received usual services (46 percent versus 21 percent and 57 percent versus 37 percent, respectively).[35,55] Another randomized controlled trial found that 85 IPS participants with SMI and justice involvement were more likely to achieve CIE than those receiving a job club approach with peer support (31 percent versus 7 percent).[54] The NextGen Project, a current study which started in 2021, is using a randomized controlled trial to evaluate the effectiveness of IPS with justice-involved adults.[36] Findings will not be available for several years, however.

Researchers have identified several adaptations to IPS for justice-involved clients. IPS workers should know

the legal rules regarding expungement, driver's licenses, and other restrictions related to justice system involvement. They also need to guide clients through complex system-related issues involving probation and parole, drug screening, and other requirements. Employers report that they hire people with criminal justice histories because they have the skills to do the job, but they also expect them to explain their justice system history, express remorse, and commit to recovery.[37] IPS trainers, therefore, recommend helping job seekers prepare to address these issues during interviews. Supporting both employers and clients is critical.

Adults in Primary Care Settings

Due to the high prevalence of mental health conditions in adults and shortages of mental health specialists, many people with anxiety, depression, or other common mental health conditions receive mental health care in primary care clinics. According to the 2006–18 National Hospital Ambulatory Medical Care Surveys regarding visits to outpatient primary care physicians by patients ages 18 and older, the proportion of visits for mental health concerns increased from 10.7 percent in 2006–07 to 15.9 percent by 2016 and 2018.[56] Primary care physicians provide the largest portion of mental health care in the U.S. (58 percent among patients with a mental health condition seeking care). Primary care physicians also practice in urban and rural areas, where seeking care from them rather than a psychiatrist may carry less stigma.[57] Further, most patients in primary care have private insurance.

For low-income and underserved populations, the Health Resources and Services Administration (HRSA) funds a growing network of nearly 1,400 Federally Qualified Health Centers (also called Community Health Centers) that provide integrated medical, dental, behavioral, and other health care services.[58,59] In 2020, nearly 29 million people across the U.S. relied on these centers for health care and social services.[59] Under Section 330 of the Public Health Service Act, these agencies receive federal funding to provide comprehensive primary care services and ensure that care is available to all, regardless of income or insurance status. There is a lack of data about access to mental health care in Federally Qualified Health Centers,[58] but the best estimate of need indicates that 20 percent of patients have a mental health condition.[60] Although Federally Qualified Health Centers aim to provide outpatient medical, behavioral health, and social services, the federal resource booklet fails to mention employment services.[61] Unsurprisingly, Federally Qualified Health Centers rarely provide supported employment services. Sometimes, however, when patients concurrently receive services in local public mental health clinics and Federally Qualified Health Centers, they can access IPS.

Patients in specialty care often have co-occurring mental health conditions. Numerous studies show that adults with chronic medical conditions, such as chronic pulmonary, cardiac, liver, and arthritic diseases, who receive specialty medical care have associated mental health conditions but do not receive mental health care and employment services.[62]

Primary care settings rarely offer IPS, but a recent randomized controlled trial evaluating the effectiveness of IPS for veterans with mental health conditions treated in primary care clinics operated by the VHA demonstrated feasibility and effectiveness: 45 percent of IPS participants gained steady employment over a 12-month period, compared to 25 percent for participants enrolled in standard vocational services for veterans.[63]

The study also found that a busy primary care setting can make it challenging to implement some elements of IPS, such as integration with the primary care team, interdisciplinary shared decision-making, and understanding of IPS principles by executive leadership and medical providers. Unlike public mental health clinics, where the IPS specialists work intensively with a treatment team, the primary care setting may not provide easy access to an interdisciplinary team meeting to include employment as part of the overall treatment plan. However, even in the primary care setting, IPS specialists can establish a network of employment resources to promote job diversity and strategic job development in the community.

Adults with Post-Traumatic Stress Disorder

An estimated 4.7 percent of U.S. adults have a post-traumatic stress disorder (PTSD) in any given year and 6.1 percent during a lifetime, with veterans, emergency responders, women, and American Indians/Alaska Natives being disproportionally affected.[64,65] Military trauma accounts for only 14 percent of the adult PTSD population, while civilian trauma represents 86 percent of cases. Women represent about two-thirds of people with PTSD. In 2018, an estimated 1.26 million adults with PTSD did not work.[66] Because few adults with PTSD receive services in the public mental health system, most do not have access to supported employment.

The VHA has done significant research on IPS for veterans with PTSD. Following an initial pilot study,[67] researchers conducted a prospective, multisite, randomized clinical trial that included 541 unemployed veterans with PTSD at 12 VHA medical centers.[68] Participants in the IPS group achieved the primary outcome (steady employment, defined as working more than half the months of the study) at a higher rate than those in the transitional work group (39 percent versus 23 percent).

The veterans study also identified key adaptations to IPS for people with PTSD. Common PTSD symptoms include avoidance of situations that remind the survivor of the trauma and can lead to social isolation that contributes to work absenteeism. IPS can serve as real-world behavioral therapy that prevents the worker living with PTSD from becoming agoraphobic, reclusive, or housebound. Symptoms of hypervigilance, anxiety, and irritability can signal a misguided response to social, interpersonal, and workplace interactions for people living with PTSD. But employment support, reframing, and guidance from an IPS specialist can help the worker overcome fear and frustration to improve workplace functioning. Thus, IPS can be a therapeutic intervention that uses employment and supportive case management as a bridge out of a sheltered and guarded existence to a more purposeful and satisfying life. Workplace accommodations can include a flexible work schedule that allows for clinical appointments, forward-facing workstations, environments that minimize loud or unexpected noises, avoidance of swing-shift work that destabilizes one's sleep-wake cycle, and tools to reduce distractions in the work area, such as white noise sound machines, sound absorption panels, or noise-canceling headsets.

Adults Experiencing Homelessness

Across the U.S., nearly 500,000 adults experience homelessness on a given night,[69] and many more are living transiently or unhoused during the year. One study estimated that 26 percent of unhoused people have a mental health condition, including 30 percent of the approximately 110,000 experiencing chronic homelessness, and 50 percent have co-occurring substance use disorders.[26] Estimates of unemployment range from 57 percent to 90 percent for this population.[70] Numerous barriers to employment exist, such as the absence of or limited access to a mailing address, computer, transportation, and physical and behavioral health care.

The most commonly available housing for people who have been homeless is permanent supportive housing, which provides housing without prerequisites, housing supports, and social and health supports. A high proportion of people in supportive housing maintain housing stability for years.[71] Yet research has suggested that adults in permanent supportive housing lack meaningful activity, social integration, and community belongingness.[72]

According to the National Coalition for the Homeless,[73] sustainable employment is the key to ending homelessness through stable housing.[74] Many supportive housing programs in the U.S. provide employment services but do not use a well-defined, research-based model. Supportive housing programs in many cities, including Cleveland, Los Angeles, and New York City, are beginning to use IPS, but the only study showing that IPS is effective in supportive housing comes from the Netherlands.[75] The Social Security Administration (SSA) currently funds the first

randomized controlled trial of IPS within supportive housing in the U.S.[76]

Immigrants, Refugees, and Asylum Seekers

Approximately 44 million people in the U.S. (13.6 percent of the population) are foreign-born.[77] Immigrants may have difficulty accessing mental health treatment due to a combination of isolation, language barriers, cultural attitudes, and stigma that inhibit recognition and treatment of mental health conditions.[78] Depending on the nature of their immigration experience, many may have suffered trauma, including physical abuse and even torture.[79] Refugees and asylum seekers have crossed international borders and are often unable or unwilling to return to their native country or country of origin because of persecution or fear of persecution. In 2019, the U.S. granted asylum status to 46,500 individuals.[80] In 2021, the U.S. admitted 11,454 refugees and asylum seekers.[81] Refugees and asylum seekers have greater rates of unemployment than other immigrants, often related to language barriers.[82] While asylees and refugees comprise only a small portion of foreign-born individuals in the U.S., they often have distinct challenges resulting from hardship, displacement, and trauma. Many live under stressful circumstances that affect them physically and psychologically, with high rates of major depression and PTSD.[83,84] Stable employment helps them to integrate into society and manage their mental health conditions.[85-87] However, language barriers, stigma around mental health, and cultural bias are common barriers to employment.[88]

At least one refugee center has implemented IPS. The Arab Community Center for Economic and Social Services, a nonprofit organization located in Dearborn, Michigan, provides a range of services to refugees, including physical and mental health care, after-school programs, and employment services.[89] In 2015, the organization incorporated the IPS model with funding from the Michigan Behavioral Health and Developmental Disabilities Administration. The IPS specialists are Arabs themselves, understand Arab culture, and speak Arabic. Over the years, they have gained the trust of the local community and their clients through advocacy and by educating employers to overcome stigma and other barriers. Because language is a major barrier, IPS specialists help clients balance English classes and employment. In 2019, 75 percent of clients receiving IPS services obtained CIE. Employed refugee clients reported improvement in overall well-being and family life.

Conclusion

IPS has spread rapidly within the U.S. public mental health system over the past 20 years, expanding from three pilot programs in 2001 to more than 1,000 programs in 2023. But these programs exist almost exclusively in the public mental health system and reach less than 1 percent of unemployed adults with a mental health condition, most of whom do not receive services in the public mental health system. Extending IPS services to vulnerable groups outside of the public mental health system – a large population that disproportionately includes people from underserved communities – presents a critical challenge. At least one million and likely several million unemployed adults with a mental health condition could benefit from IPS supported employment.

Early adopter efforts, already underway for some of these groups, serve several important functions: developing effective adaptations to the IPS model for specific populations; establishing efficacy and return on investment; enhancing advocacy; and demonstrating that historically underserved groups could benefit from this expansion. The U.S. has been slower than many other countries to recognize that employment is a critical health intervention that promotes functional recovery for people with a mental health condition.

The principles of IPS remain essentially the same across diverse populations, and implementation adjustments can address specific groups and settings, such as individuals with substance use disorders and those involved in the criminal justice system. One foundational principle of IPS – the integration of vocational and health services – may be essential to health benefits because employment services enhance

access to needed health services for many people who are hesitant to use mental health care. Early psychosis programs, where the desire for education and employment motivates young people to participate in mental health care, have already demonstrated this positive outcome of IPS.

Extending IPS services could enable new populations to achieve CIE, greater independence, and better mental health. Such extension presents a major policy challenge at federal, state, and local levels, because it is simultaneously a disability issue, workforce issue, economic issue, disparity issue, community integration issue, recovery issue, and health issue. Nevertheless, extending IPS is essential to achieving shared goals for the health and well-being of people with mental health conditions across all related systems.

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