IPS for New Populations

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Introduction

Individual Placement and Support (IPS) is an evidence-based supported employment model developed in the 1990s for clients with serious mental illness (SMI) (Becker & Drake, 1993). The evidence base includes over two-dozen rigorous evaluations – randomized controlled trials (RCTs) – showing positive employment outcomes for IPS (Drake & Bond, 2023). Multiple systematic reviews and meta-analyses have documented IPS effectiveness in improving employment outcomes for this population (Bond et al., 2012; Brinchmann et al., 2020; de Winter et al., 2022; Frederick & VanderWeele, 2019; Modini et al., 2016). No other vocational model has been studied as rigorously or as extensively as IPS for any health condition or disability group (Bond, Drake, et al., 2025).

Starting in the decade after the initial pilot study of IPS in rural, predominantly White NH (Drake, Becker, et al., 1996) and first RCT of IPS in two small NH cities (Drake, McHugo, et al., 1996), researchers and program leaders began exploring whether the IPS model could be equally effective people with SMI with different characteristics and in different circumstances. The first IPS RCT replication in Washington, DC, showed the effectiveness of IPS for a predominantly Black population, including recently homeless clients (Drake et al., 1999). The DC study encouraged researchers and program leaders to consider IPS to other target groups within the psychiatric population.

Subsequently, in a second new direction, researchers began studying the effectiveness of IPS for people with non-SMI psychiatric disorders. The pioneering study was an RCT of IPS for military veterans with post-traumatic stress disorder (PTSD) (Davis et al., 2012).

A third direction exploring whether the IPS model could translate beyond the population for which it was developed was the study of the effectiveness of IPS for nonpsychiatric populations. The first RCT of IPS for people with a nonpsychiatric health condition examined its suitability for military veterans with spinal cord injuries (Ottomanelli et al., 2012). IPS has since expanded to serve a range of nonpsychiatric groups (Bond et al., 2019; Probyn et al., 2021)

This issue brief updates the research on the effectiveness of IPS for new populations and targeted subgroups within the psychiatric population. The brief focuses on RCTs, which provide the best evidence on effectiveness. The brief includes brief summaries of findings and recommendations for further research and practice.

In this brief, "standard IPS program" refers to an IPS program with a caseload consisting primarily of working-age adults with SMI. Most of the studies discussed in this brief refer to IPS programs serving a different group than standard IPS programs, though in some instances, IPS programs have mixed caseloads serving both the traditional target group (people with SMI) and the new population. For example, in some states, people with autism spectrum disorder can enroll in standard IPS programs.

The literature review is organized into five categories: (1) Subgroups of the psychiatric population defined by background, (2) Subgroups defined by mental health diagnosis, (3) Young adults with mental health conditions, (4) Substance use disorders, and (5) Musculoskeletal and neurological disorders. Table 1 summarizes details of 14 RCTs of IPS for populations with mental health diagnoses other than SMI, substance use disorders, and musculoskeletal and neurological disorders.

Subgroups of the Psychiatric Population Defined by Background Characteristics, History, or Life Circumstances

A key IPS principle is *zero exclusion,* which means anyone with a serious mental health disorder who wants to work in a competitive job is eligible to enroll in IPS, regardless of background characteristics or history. Over the last three decades, program leaders and researchers have offered IPS to a variety of subgroups within the psychiatric population based on the assumption that IPS would benefit these subgroups.

Based on many IPS studies, one general finding is that IPS is effective regardless of background characteristics, history, or life circumstance. IPS improves employment outcomes for nearly every subgroup defined by specific background characteristic or life circumstance, including gender, education, marital status, psychiatric hospitalization history, disability status, and work history (Campbell et al., 2011; Metcalfe et al., 2017). Until recently, most of this research has been conducted on IPS for people with SMI. Based on rigorous research (RCTs), IPS is effective for people with SMI with co-occurring substance use disorders (Mueser et al., 2011) and people with mental health conditions and criminal justice involvement (Bond et al., 2015; LePage et al., 2020; LePage et al., 2016); IPS is effective for middle-aged and older adults (Twamley et al., 2008), Black and Hispanic clients (Bond, Mascayano, et al., 2023), military veterans (Davis et al., 2018; LePage et al., 2020), and disability beneficiaries (Drake et al., 2013).

The IPS model is only effective, however, for people who want to work. This point is self-evident, but it is also a crucial qualification for delineating which groups may *not* benefit from IPS. Not surprisingly, IPS is ineffective for people who are not interested in working. Studies enrolling people with no expressed interest in working have found that IPS participants have poor employment outcomes (Lehman et al., 2002) and high dropout rates (Metcalfe & Drake, 2022). Similarly, requiring people to work in order to receive government benefits (e.g., health insurance, welfare payments, food stamps) has proved to be poor policy that does not increase employment rates (Gangopadhyaya & Karpman, 2025). Work requirements do not increase the intrinsic motivation to work. Consistent with policy studies examining the impact of work requirements on social programs, IPS research also suggests that IPS is not suited to help beneficiaries of social welfare programs who have external requirements to work or look for work. For example, a Dutch RCT found no improvement in employment outcomes for IPS participants who had work requirements as a condition to receive welfare benefits (Oude Geerdink et al., 2024). Similarly, a study in Los Angeles evaluating IPS for recipients of Temporary Aid to Needy Families (TANF) reported only modest results favoring IPS (Chandler, 2017).

In summary, IPS has generally been effective helping unemployed people of all backgrounds and characteristics who want to work, and specifically, who want to work in the near future. Requiring people to work as a condition for receiving benefits is contrary to the principle that IPS is designed for people who are intrinsically motivated to work.

A practical suggestion for practitioners is to interview prospective IPS participants during the enrollment process to ensure that they want to work a competitive job, and that this is their own preference, and not that of their case manager, a family member, or another service agency. It is also critical that participants have a near-term goal of working. If some other goal or pressing need (e.g., medical problems) is an urgent priority, it may make sense to delay IPS enrollment.

Subgroups Defined by Mental Health Diagnosis

SMI. This brief is devoted to summarizing the effectiveness of IPS for new populations. By way of background, we first briefly summarize the findings on IPS for people with SMI. A large body of research, including several reviews and numerous large-scale studies have found that IPS is especially effective for the target group for which it was first designed – people with SMI, including people with schizophrenia and bipolar disorder (de Winter et al., 2022; Hellström et al., 2021). Virtually every study evaluating IPS for people with SMI has found IPS more effective than any alternative program. Similarly, many meta-analyses have shown IPS to be more effective than standard vocational services for improving employment outcomes. The most comprehensive of published reviews is a meta-analysis of 32 RCTs of IPS (28 for people with SMI), which found 49% of IPS participants compared to 28% of control participants gained employment during follow-up, odds ratio (OR) = 2.62 [2.37–2.89], $p < 0.01$) (de Winter et al., 2022). These statistics can be used as benchmarks for interpreting the strength of findings in RCTs of IPS for other disorders.

PTSD. As shown in Table 1, two RCTs found IPS improved employment outcomes for veterans with PTSD (Davis et al., 2018; Davis et al., 2012). The findings were strong in the first small RCT (OR = 8.67). The second study, a large multi-site RCT, also found significant differences favoring IPS, but the effect size was small (OR = 1.65). Research on the effectiveness of IPS for PTSD in the civilian population is needed.

CMD. Common mental disorders (CMD) is a term used to encompass anxiety disorders and depressive disorders (de Winter et al., 2022). CMD and SMI are considered mutually exclusive categories. As shown in Table 1, five RCTs have evaluated IPS in psychiatric populations comprised mainly of people with CMD, though several included mixed diagnostic subgroups (including SMI in some cases) (Bejerholm et al., 2017; Davis et al., 2022; Freedman et al., 2025; Hellström et al., 2017; Reme et al., 2019).

Of the two US RCTs of IPS for people with CMD, one found significant employment outcomes favoring IPS. Davis et al. (2022) evaluated an IPS program for military veterans with nonpsychotic psychiatric disorders (mainly depressive disorders and PTSD) who were receiving medical care from a Veterans Health Administration primary care clinic. The researchers reasoned that veterans would be receptive to receiving vocational help through this location to be less stigmatizing than at a mental health center. Although the employment rates did not differ for IPS and the control group, IPS had significantly better employment outcomes on most measures. Among three Scandinavian studies, one small RCT for people with affective disorders found employment outcomes favoring IPS (Bejerholm et al., 2017), but the other two did not (Hellström et al., 2017; Reme et al., 2019).

Studies evaluating the effectiveness of IPS for people with CMD have been complicated by the settings where participants have been recruited and the specific circumstances that have led them to seek vocational help. While the large majority of IPS studies for people with SMI have been conducted in community mental health centers, this is not true for IPS studies for people with CMD, which have often included participants who have been on sickness leave of absence and intend to return to their place of work. Participants who already have a job and are returning to work are not looking for a new job and as such are unlikely to use an individualized job search like IPS (Reme et al., 2015). IPS studies comparing outcomes for SMI and CMD subgroups have found that IPS has been effective for people with SMI but not CMD (Hellström et al., 2021; Holmås et al., 2021).

Summary and recommendations. The evidence favoring IPS for people with SMI is clearcut. People with SMI who want to work should have access to IPS. The evidence for IPS for veterans with PTSD is promising and IPS should also be available to this group. Research in the civilian populations is needed.

Studies of IPS for people with CMD have mixed results, including three of five studies finding no differences for people with CMD between IPS and controls on any employment outcomes. Research is needed to clarify whether the lack of positive findings for this group is influenced primarily by psychiatric diagnosis or by external factors, such as circumstances prompting them to seek employment assistance (for example, returning to work at an existing job or being required to work to receive welfare payments).

The only RCT of IPS for people with CMD conducted in a mental health treatment setting found a strong impact for IPS (Bejerholm et al., 2017). It is possible that IPS may be effective for community mental health center clients with CMD who have been unemployed for a long time and are not returning to work at a previously held job.

Based on the preponderance of evidence, standard IPS cannot be recommended for workers with CMD on sickness leave of absence planning to return to work. For this group, an employment intervention that incorporates a systematic focus on workplace accommodations (e.g., shorter work hours), ongoing support in the workplace, and close integration with mental health treatment may be keys to improved employment outcomes (Hellström et al., 2018).

Young Adults with Mental Health Conditions

In the IPS literature, one subgroup that has been studied extensively is the young adult population. Young adults aged 16-24 comprise a target group of great concern to mental health leaders. Mental health issues, including anxiety and depression, have been increasing steadily for more than a decade, not only in the US (Bond, Al-Abdulmunem, et al., 2023), but also internationally (Lock, 2025). Many young adults are disengaged and lacking productive daytime activities, a pattern termed *Not in Employment, Education, or Training* (NEET) (Mawn et al., 2017). While many young adults in the NEET population have received formal psychiatric diagnoses, others have not.

The young adult population also includes a large subgroup experiencing an early episode of psychosis, many of whom receive treatment in hundreds of coordinated specialty care (CSC) programs throughout the US (Read & Kohrt, 2022). The CSC service model includes supported employment and education as a key program component (Heinssen & Azrin, 2022). It appears likely, however, that only a small proportion of CSC teams nationwide adhere to IPS fidelity (Addington et al., 2020).

Mental health leaders recognize that IPS could benefit the many youth and young adults facing challenges achieving employment. Unlike older adults, young adults typically have both employment and education goals, which has led to expansion of the IPS model to include supported education (Swanson et al., 2017). From the beginning, standard IPS programs in community mental health centers have served young adults (but rarely those under the age of 20) (Bond et al., 2016).

The research is strong and consistent that IPS is effective in helping young adults achieve positive competitive employment outcomes. A systematic review of 7 RCTs found that nearly twice as many IPS participants as control participants were competitively employed during follow-up (Bond, Al-Abdulmunem, et al., 2023). Recently, an eighth RCT found comparable results (Jäckel et al., 2025). The combined findings for the 8 RCTs from the systematic review and the Jäckel study are: 60% of 396 IPS participants and 35% of 379 control participants gained competitive employment during follow-up (OR = 2.88 [95% Confidence Interval: 2.15, 3.86], p

< .001). These statistics are similar to benchmarks cited above for IPS for people with SMI (IPS (49%) vs. Control (28%), OR = 2.62).

Four of the studies in the young adult review also examined education outcomes (Bond, Al-Abdulmunem, et al., 2023). Although none of the individual studies found significantly better education outcomes for IPS, the finding was significant when combining results for all four studies.

Summary and recommendations. The evidence regarding the effectiveness of IPS for young adults is strongly positive. To date, most RCTs (5 of the 8) have evaluated IPS for young adults with early psychosis. Young adults with SMI also appear to benefit from IPS, but more research is needed (Bond et al., 2016). Controlled research also is needed to evaluate IPS for other young adult subgroups, such as those diagnosed with either an anxiety or depressive disorder or have not yet been diagnosed with a mental health condition. A large Australian program evaluation found encouraging results for this non-SMI subgroup (Simmons et al., 2023).

Thus, young adults with a variety of mental health conditions appear to greatly benefit from IPS. Most research suggests young IPS participants are as successful gaining employment as older IPS participants (Campbell et al., 2011). Some studies suggest that young adults may be more successful than older adults (Holmås et al., 2021; Metcalfe et al., 2017).

According to clinical wisdom, young adults find jobs easily but have difficulties keeping jobs. Studies do show that young adults in IPS programs change jobs more often than do older adults, which also holds true in the general population (Bond et al., 2024). Thus, one challenge for IPS programs is retaining young adults in IPS programs long enough for them to find good job matches. For this reason, IPS specialists need outreach strategies tailored to young adults (Florence et al., submitted). IPS services for young adults also differ from those for older adults in that young adults have education goals in addition to employment goals. Another difference for many young adults, especially those still living at home, is the inclusion of family members in supporting young adults in the employment process.

IPS program leaders have many resources for serving young adults, including a practice manual (Swanson et al., 2017) and the IPS-Y, a modified version of the standard IPS fidelity scale for young adults, which was developed to incorporate adaptations for this population (Bond, Swanson, et al., 2025). The IPS-Y includes only minor changes to the standard IPS fidelity scale, but it adds a new subscale for supported education and an item encouraging family involvement. One key finding is that existing IPS fidelity standards for employment services are sufficient for young adults to achieve good employment outcomes (Bond, Swanson, et al., 2025).

Substance Use Disorders

Standard IPS programs typically include a substantial proportion of people with co-occurring substance use disorders. Studies have consistently found that IPS is effective for the population of people diagnosed both with a psychiatric disorder and a substance use disorder (Harrison et al., 2020; Mueser et al., 2011). One review concluded that people with a co-occurring substance use disorder are as successful in employment as people with SMI without such a diagnosis (Sengupta et al., 1998).

Recently, researchers have evaluated IPS for people with a primary diagnosis of substance use disorder. As shown in Table 1, five RCTs have been completed (LePage et al., 2020; LePage et al., 2016; Lones et al., 2017; Marsden et al., 2024; Rognli et al., 2025). Of the three US studies, two examined IPS for veterans with a criminal justice history and substance use disorder and both found employment outcomes favoring IPS (LePage et al., 2020; LePage et al., 2016). A small RCT of IPS for participants with opioid disorder attending a methadone clinic found significantly better employment outcomes for IPS than controls (Lones et al., 2017).

Two larger studies have found weaker outcomes favoring IPS. The first was a UK trial, which found small but significant effects favoring IPS (Marsden et al., 2024). The employment rate was 30% for IPS and 25% for controls. IPS had significantly better employment outcomes than controls for the subgroups with alcohol use disorder and drug use disorder (e.g., marijuana), but IPS was not found effective for participants with opioid use disorder. The UK government has launched a national rollout of IPS for substance use disorder, which will provide more information about the effectiveness of IPS with this population. The recruitment and follow-up period overlapped with the COVID lockdown, which may have affected employment outcomes. Another factor that may have influenced outcomes was the initial challenge of integrating IPS into substance use treatment centers.

The second, a Norwegian trial, had mixed results (Rognli et al., 2025). The researchers found no difference in the percentage obtaining employment during follow-up, but IPS participants averaged significantly more hours working and a higher total salary than control group participants. In this study as well, the recruitment and follow-up period overlapped with the COVID lockdown, which may have affected employment outcomes.

Summary and recommendations. As shown in Table 1, although 5 RCTs of IPS for substance use disorders have found employment outcomes favoring IPS, three of these studies with strong outcomes were pilot studies, while the two larger studies found only modest outcomes favoring IPS. Whether the type of substance use influences outcomes is unclear. A pilot study found strong results favoring IPS for people with opioid use disorder, while the large UK study found no differences. Regarding research recommendations, a large US trial is needed.

Based on the overall positive findings from these five RCTs and previous research demonstrating that people with co-occurring mental health and substance use disorders benefit from IPS, the recommendation at this time is to offer IPS to people with a primary diagnosis of substance use disorder, recognizing that its impact on employment may be less for this group than it is for people with SMI. Some anecdotal evidence suggests that part of the challenge in obtaining strong outcomes has been inadequate implementation of IPS. Implementing IPS teams in substance abuse treatment centers poses a major challenge that may limit effectiveness. Mature, high fidelity IPS programs may achieve better employment outcomes.

Musculoskeletal and Neurological Disorders

Musculoskeletal and neurological disorders include injuries or pain affecting the musculoskeletal system and neurological impairments affecting role functioning, including work functioning. Although rehabilitation programs for people with musculoskeletal and neurological disorders are widespread, US rehabilitation programs usually address aspects of physical rehabilitation such as mobility and tasks of daily living, but they seldom include vocational rehabilitation interventions. As shown in Table 1, two RCTs have been conducted of IPS for these disorders.

Spinal cord injury. An RCT of IPS for US military veterans with spinal cord injury found a significantly higher employment rate for IPS than controls (31% vs.11%) (Ottomanelli, Barnett, & Goetz, 2014). The IPS model required substantial modification for this population, including the integration of employment services with the medical treatment for spinal cord injury rather than with mental health care and different approaches to disclosure and job development (Ottomanelli, Barnett, & Toscano, 2014).

Pain: One small RCT was conducted in Norway of IPS for patients with chronic pain (Sveinsdottir et al., 2022). IPS participants achieved a higher employment rate than controls during two-year follow-up (60% vs. 41%), but this difference did not reach significance. The small sample size of 54 at 2-year follow-up was a study limitation. More research with larger samples is recommended, but this pilot study is an encouraging first step. Integrating IPS services into pain clinics in the US is likely to be a major challenge, but this Norwegian study has shown that this integration is possible.

Summary and recommendations. Currently only two small RCTs of IPS for people with musculoskeletal and neurological disorders have been completed. These studies establish the feasibility of providing IPS in settings serving people with these conditions. However, the absence of replications suggests caution to making strong recommendations. Logistically, implementing IPS that may lack a strong ethos emphasizing the importance of work may impede its adoption. Funding may be another challenge.

Conclusions and Implications for Practice

This issue brief summarized research on the effectiveness of IPS for people with various groups defined by background characteristics, mental health diagnosis, age, substance use disorders, and musculoskeletal and neurological disorders, based on two meta-analyses and 14 individual studies. The summary leads to several conclusions:

1. One general finding is that no subgroup receiving IPS has had worse outcomes than control participants receiving standard services. We can confidently conclude that IPS has not resulted in negative effects for any group and in fact, no alternative vocational model has been found more effective than IPS for any population. The eight principles guiding IPS implementation are pragmatic and applicable to people who are unemployed and need help finding and keeping jobs. IPS principles are not tailored to, and therefore limited to, people with specific diagnoses or background characteristics.
2. IPS has established effectiveness in multiple studies for people with SMI and young adults with early psychosis. IPS should be accessible to people from both groups who seek help with employment.
3. IPS is a promising approach for veterans with PTSD and should be made available to this group. A study is needed to evaluate whether these findings generalize to a civilian

population consisting of adults with PTSD. There are no obvious reasons why IPS would not be equally effective for civilians as for veterans.

4. Notably, all six RCTs of IPS for US military veterans found positive employment outcomes favoring IPS (Davis et al., 2018; Davis et al., 2012; Davis et al., 2022; LePage et al., 2020; LePage et al., 2016; Ottomanelli, Barnett, & Goetz, 2014). Veterans may be especially well suited for IPS. The consistency of positive findings for veterans is simply an observation; it is not bolstered by any obvious theoretical explanation.
5. For people with substance use disorders, IPS has been found effective in five RCTs, but three studies with strong results are pilot studies, while two larger studies had modest effect sizes. Both of the larger studies were conducted during the COVID lockdown, which may have reduced the effects. Research is needed to clarify if IPS needs modification to be maximally effective for this population.
6. While a substantial number of RCTs of IPS for CMD have been conducted, the results have been mixed. Based on current evidence it appears likely that IPS is less effective for people with CMD than for people with SMI. Many of the published studies have been conducted in samples of workers on leave of absence seeking to return to work, a distinctly different population than IPS has traditionally served. It is possible that the return-to-work group needs a package of employment interventions emphasizing workplace accommodations and mental health treatment.
7. The results from two small studies of IPS for patients with musculoskeletal and neurological disorders are encouraging, demonstrating that IPS is feasible in rehabilitation settings outside of mental health treatment. Further development of IPS in these settings is recommended.

Future Directions

Researchers have examined the effectiveness of IPS for people with other psychiatric diagnoses. For example, preliminary observational data suggesting IPS may be beneficial for people with personality disorders (Juurlink et al., 2022), despite interpersonal conflicts (Dunand et al., 2024). Small RCTs are underway examining IPS for people with borderline personality disorder (Chanen et al., 2020) and obsessive compulsive disorder (Patel et al., 2024).

In most states, the state mental health authority oversees services for people with mental health disorders, while a separate state agency (or department within an umbrella agency) administers services to people with developmental and intellectual disabilities. The latter group typically receive employment services through comprehensive rehabilitation agencies. IPS appears to be rarely offered to this population. The only published research on IPS for this population is a pilot evaluation of IPS for young adults with developmental disabilities, which reported modest success (Noel et al., 2018).

One subgroup within this population that has received a lot of attention from IPS leaders are people with autism spectrum disorders (Florence, Mueser, et al., 2025). Within this subgroup are some who receive services through community mental health centers, where they have access to IPS (Florence, Mulcahy, et al., 2025). Very little research has been published on IPS for people with autism spectrum disorder. One small case study reported positive outcomes (McLaren et al., 2017).

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Table 1 . Randomized Controlled Trials of IPS for Other Conditions

Primary Investigator (Year)	Country	Sample Characteristics	Final Sample Size	Months of Follow-up	Employment Rate at Follow-up with Odds Ratio and 95% confidence interval	Findings	Comparison Group	Level of IPS Fidelity	Modified IPS?
Post-Traumatic Stress Disorder									
Davis (2012)	US	Military veterans with PTSD	85	12	IPS (76%) vs Ctl (28%) OR=8.27 [3.12, 21.89] p<.001	IPS had significantly better employment outcomes: IPS > Controls on weeks worked and employment earnings	Sheltered & transitional employment	Fair	
Davis (2018)	US	Military veterans with PTSD	541	18	IPS (69%) vs Ctl (57%) OR=1.65 [1.16,2.34] p=.005	IPS had significantly better employment outcomes: Steady employment rate: IPS (39%) vs Control (23%) IPS > Controls on weeks worked and employment earnings	Sheltered & transitional employment	Fair to good	
Common Mental Disorder (Anxiety and Depression)									
Hellström (2017)	Denmark	Workers on sick leave aiming to return to work; CMD (90%); Bipolar (10%)	326	24	IPS (44%) vs Ctl (38%) OR=1.34 [0.86, 2.10] ns	No difference between IPS and control on any employment outcome	Stepwise job services	Not measured, but likely low	Modified for RTW
Bejerholm (2017)	Sweden	Affective disorder: CMD (69% with depressive disorder), SMI (31% with bipolar disorder).	61	12	IPS (42%) vs Ctl (4%) OR=17.68 [2.13, 146.76] p < .05	Significant difference favoring IPS on other employment measures (hours worked, earnings)	Traditional VR	High	"enhanced IPS"
Reme (2019) Holmås (2021)	Norway	Moderate/severe mental illness (SMI -- 38%, CMD -- 62%)	410	18 (also 43)	CMD results were: IPS (38%) vs Ctl (26%) OR=1.68 [0.86, 3.28] ns	Significant differences favoring IPS in total sample at 12 months and 18 months; no difference for either SMI or CMD subgroups. At 43 mos, IPS > Ctl in full sample and for SMI but not for CMD.	Stepwise job services	Fair to exemplary	none mentioned
Davis (2022)	US -- VHA	Primary care clinic: Veterans with nonpsychotic psychiatric disorders or CMD or PTSD (most had depression, some PTSD)	119	12	IPS (62%) vs Ctl (51%) OR=1.58 [0.77, 3.29] ns	Steady employment rate: IPS (45%) vs Ctl (25%), p=.02 IPS > Controls on weeks worked and employment earnings	Sheltered & transitional employment	Fair to good	IPS colocated in primary care
Freedman (2025)	US	People with self-identified disabilities referred from American Job Centers, MH and TANF. Common disabilities were MH or depression	1061	24	IPS (61%) vs Ctl (60%) OR=1.04 [0.81, 1.33] ns (Year 2)	Employment outcomes (employment rate and earnings) significant in Year 1 but not in Year 2	Usual community resources	Not reported	

Table 1 . Randomized Controlled Trials of IPS for Other Conditions (Continued)

Primary Investigator (Year)	Country	Sample Characteristics	Final Sample Size	Months of Follow-up	Employment Rate at Follow-up with Odds Ratio and 95% confidence interval	Findings	Comparison Group	Level of IPS Fidelity	Modified IPS?
Substance Use Disorders									
LePage (2016)	US	US veterans with a criminal justice history. 88% with substance use disorder, 67% homeless in last year.	84	6	IPS (46%) vs Ctl (21%) OR=3.15 [1.19, 8.33] p=.05	Days worked: IPS (43.8) vs Ctl (20.7), p=.03 Earnings: IPS ($1401) vs Ctl ($694), p=.04	Manualized group career counseling	Fair	IPS group also received group counseling
LePage (2020)	US	US veterans with a criminal justice history. 81% with substance use disorder, 51% with depressive disorder	111	12	IPS (57%) vs Ctl (37%) OR=2.20 [1.03, 4.73] p=.04	Months worked: IPS (4.2) vs Ctl (2.3), p=.03 Earnings: IPS ($6953) vs Ctl ($5184), p=.02	Manualized group career counseling	Fair	IPS group also received group counseling
Lones (2017)	US	People with opioid disorder treated at a methadone clinic	45	6	IPS (50%) vs Ctl (4%) OR=22.00 [2.51, 192.93] p<.001		Waitlist	Fair	IPS specialist colocated with treatment team
Marsden (2024)	UK	People receiving treatment at substance use treatment centers for alcohol (N=610), and drugs (N=240), and opioid (N=837)	1687	18	IPS (30%) vs. Ctl (25%) 1.29 [1.02, 1.64] (adjusted odds ratio) p<.05	Significant effects within alcohol and drug subgroups but not opioid subgroup. No difference in sustained employment comparing IPS to Ctl	Local community resources	Fair to good	
Rognli (2025)	Norway	Patients treated for SUD at hospital; main diagnoses were for alcohol (30%), heroin (50%), cannabis (20%)	187	18	IPS (40%) vs. Ctl (34%) OR=1.28 [0.70, 2.35] ns	Hours worked: IPS (601) vs. Ctl (304), p<.05 Earnings: IPS (141000) vs Ctl (73000), p<.05	Self-help guidebook + workshop	Fair	
Musculoskeletal and Neurological Disorders									
Ottomanelli (2014)	US	Multisite study wiuth referrals from spinal cord injury providers	140	24	IPS (31%) vs Ctl (11%) OR=3.79 [1.59, 9.07] p<.001		Referral to VR	Fair	IPS specialist integrated into SCI team
Sveinsdottir (2022)	Norway	Patients with chronic pain referred from a hospital pain clinic	54	24	IPS (60%) vs Ctl (41%) OR=2.10 (0.65, 6.74) ns	Hours worked: IPS (217) vs. Ctl (123), ns	Resource manual + interdisciplinary pain treatment	Fair	IPS integrated with pain clinic team