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# Individual Placement And Support Services Boost Employment For People With Serious Mental Illnesses, But Funding Is Lacking

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**ABSTRACT** The majority of people with serious mental illnesses want to work. Individual placement and support services, an evidence-based supported employment intervention, enables about 60 percent of people with serious mental illnesses who receive the services to gain competitive employment and improve their lives, but the approach does not lead to fewer people on government-funded disability rolls. Yet individual placement and support employment services are still unavailable to a large majority of people with serious mental illnesses in the United States. Disability policies and lack of a simple funding mechanism remain the chief barriers. A recent federal emphasis on early-intervention programs may increase access to employment services for people with early psychosis, but whether these interventions will prevent disability over time is unknown.

**T**he opportunity to work determines income, influences many aspects of health, and facilitates social inclusion. Conversely, unemployment leads not only to poverty but also to depression, substance abuse, chronic illness, family conflict, dependence on government programs, and crime.

For people with disabilities, employment serves many personal, societal, and governmental goals, such as increased self-esteem, social integration, and community participation. People with a psychiatric disability view employment as a primary treatment goal and supported employment as a critical intervention that enables them to find and succeed in satisfying jobs. These issues are especially important for people with serious mental illnesses because most are unemployed and dependent on government assistance.

People with serious mental illnesses leading to psychiatric disability are among the most disenfranchised groups in the United States. About 5 percent of working-age US adults have impair-

ments as a result of serious mental illnesses such as psychotic and severe mood disorders.<sup>1</sup> Approximately two-thirds of clients with mental illnesses in community mental health agencies want to work,<sup>2</sup> and yet only about 15 percent are employed.<sup>3–5</sup>

Despite these sobering statistics, many people with a psychiatric disability could achieve competitive employment because of the emergence of an effective intervention: evidence-based supported employment, also called individual placement and support.<sup>6</sup> In this article we review recent research on evidence-based supported employment and discuss the progress, barriers, and policies related to expanding employment services. We discuss individual placement and support for the long-term unemployed with serious mental illnesses as well as its use for early intervention. Finally, we consider public policy issues surrounding individual placement and support funding and implementation.

## Individual Placement And Support

Individual placement and support offers a pragmatic, person-centered, relatively inexpensive approach to helping people with psychiatric disabilities find and succeed in competitive jobs.<sup>7</sup> The client of an agency offering individual placement and support services chooses when he or she is ready to work and identifies preferences for type of job, desired hours of work, participation in the job search, and type and amount of supports needed on the job. The individual placement and support specialist, usually working within and paid by a community mental health agency, helps the client find a preferred job, coordinates closely with mental health professionals, provides counseling regarding benefits, and offers supports to help maintain employment. The individual placement and support model avoids extensive assessments, pre-employment training, and demonstrations of readiness.

Individual placement and support, developed at the Dartmouth Psychiatric Research Center in the early 1990s, has steadily demonstrated effectiveness across many populations, in different countries, and under diverse economic conditions. The cost in US dollars for individual placement and support averages about \$3,500–\$5,000 per client in the first year after enrollment.<sup>8</sup> The costs are incurred primarily in the first nine months, when the individual placement and support specialist has weekly contacts, on average, to help the client find an appropriate job, become hired, and learn the job tasks; after approximately nine months or whenever the client is settled in a job, supports decrease to once a month,<sup>9</sup> thereby reducing costs substantially.

## Individual Placement And Support For People With Long-Term Disabilities

**RESEARCH** The effectiveness of individual placement and support for increasing employment outcomes has been demonstrated in twenty-three randomized controlled trials conducted over the past two decades (Exhibit 1). These controlled trials, conducted both inside and outside the United States, have included more than 5,000 people with serious mental illnesses who were followed for an average of nineteen months. Most individual placement and support clients attain competitive employment within nine months, work half time or more, and earn above minimum wage.<sup>6</sup> They are satisfied with their jobs but rarely leave the Social Security disability rolls completely.

Across many studies, the percentage of individual placement and support clients obtaining competitive employment during follow-up peri-

ods ranging from six months to five years is about 60 percent,<sup>10</sup> which is two to three times higher than for clients receiving other vocational interventions (Exhibit 1). Average employment tenure in an initial job is eight to ten months,<sup>11</sup> and steady work leads to enhanced self-esteem and higher quality of life.<sup>12</sup> Several studies also show reduced mental health service use,<sup>13,14</sup> implying better clinical as well as functional outcomes. Individual placement and support is more effective, compared with other vocational services, for different subgroups—defined, for example, by sex, race, ethnicity, age, substance abuse comorbidity, or work history—as documented in reviews,<sup>10</sup> a meta-analysis,<sup>15</sup> and a large multisite study.<sup>16</sup>

In addition to controlled trials, data from numerous community mental health centers corroborate findings that individual placement and support programs help clients gain employment. A national individual placement and support learning community (including mental health clients, their families, mental health and vocational professionals, state departments of mental health and vocational rehabilitation, trainers, and researchers) began in 2002 in three states and has steadily spread to twenty states, with others planning to join.<sup>17</sup> The learning community has helped create leadership, infrastructure, training, supervision, fidelity assessments, and routine outcome data collection within states, across the United States, and in some European countries. It has offered education and training online, an annual conference, and participation in numerous research studies aimed at improving services. Employment rates for the program's clients have remained consistently strong (more than 40 percent per quarter) since the learning community's inception, even during the recent recession.<sup>17</sup>

Several controlled studies have found that individual placement and support is cost-effective compared with other vocational services.<sup>14,18</sup> For example, in a five-year study in Switzerland, which considered only employee earnings (and did not consider quality of life or other subjective benefits), the return on investment (defined as employment earnings divided by mental health treatment and rehabilitation costs), translated into US dollars, was 54 cents per dollar spent for individual placement and support, compared to 18 cents per dollar spent for other vocational services.<sup>14</sup> In addition, several controlled trials found that individual placement and support clients used a hospital for fewer days than control-group clients.<sup>13,14,19</sup> Over the long term, clients who achieve steady employment use fewer mental health services than those who do not achieve steady employment.<sup>20</sup>

## EXHIBIT 1

## Results of twenty-three randomized controlled trials of individual placement and support (IPS) employment services

Author, year published	Study site	Control condition	Months of follow-up	Number of participants		Study population	Percent obtaining competitive employment	
				IPS	Control		IPS	Control
Drake, 1996	Manchester and Concord, NH	Skills training, nonintegrated	18	73	67	CMHC clients	78%	40%
Drake, 1999	Washington, DC	Enhanced vocational rehabilitation	18	74	76	Case management program clients	61	9
Lehman, 2002	Baltimore, MD	Psychosocial rehabilitation program	24	113	106	CMHC clients, including those without vocational goals	27	7
Mueser, 2004	Hartford, CT	(1) Brokered supported employment; (2) psychosocial rehabilitation	24	68	136	CMHC clients	75	23
Gold, 2006	Rural SC	Sheltered workshop	24	66	77	CMHC clients	64	26
Latimer, 2006	Montréal, Québec	Traditional vocational services	12	75	74	Clients receiving MH services	47	19
Bond, 2007	Chicago, IL	Diversified placement approach	24	92	95	New admissions to psychosocial rehab agency	75	34
Burns, 2007	Six cities in Europe	Traditional vocational services	18	156	156	Clients receiving MH services	55	28
Wong, 2008	Hong Kong	Vocational rehabilitation referral	18	46	45	Hospital and community referrals	70	29
Killackey, 2008	Melbourne, Australia	Traditional vocational services	6	20	21	Early psychosis program	65	10
Nuechterlein, 2010	Los Angeles, CA	Vocational rehabilitation referral	18	36	15	Psychiatric hospitals and clinics plus university outpatient	69	33
Heslin, 2011	London, England	Usual care	24	93	95	CMHC clients	22	12
Twamley, 2012	San Diego, CA	Vocational rehabilitation referral	12	30	28	Middle-age and older adults (ages 45 and older)	57	29
Davis, 2012	Tuscaloosa, AL	Usual Veterans Affairs vocational rehabilitation	12	42	43	Unemployed veterans with PTSD	76	28
Killackey, 2012	Melbourne, Australia	Traditional vocational services	6	67	59	Early psychosis program	72	48
Drake, 2013	23 US sites	No additional services	24	1,004	1,051	SSDI recipients	52	33
Oshima, 2014	Tokyo, Japan	Usual care	6	18	19	High-need and frequently hospitalized clients	44	11
Michon, 2014	Four cities in Holland	Traditional vocational services	30	71	80	Clients receiving MH services	44	25
Hoffmann, 2014	Bern, Switzerland	Traditional vocational rehabilitation	60	46	54	Referrals from Bern University Hospital of Psychiatry	65	33
Bejerholm, 2014	Malmö, Sweden	Traditional vocational rehabilitation	18	41	46	Outpatients referred from MH treatment teams	46	11
Waghorn, 2014	Three Australian communities	Referral to disability system	12	106	102	Clients receiving MH services	42	24
Bond, 2015	Chicago, IL	Job club adaptation	12	43	44	MH clients with justice involvement	31	7
Viering, 2015	Zurich, Switzerland	No additional services	24	127	121	Disability pensioners with mental illness	32	12

**SOURCE** Updated from a previously published review by Drake RE, Bond GR, Becker DR. Individual placement and support: an evidence-based approach to supported employment (see Note 6 in text). **NOTES** The online Appendix lists the citations for these studies. To access the Appendix, click on the Appendix link in the box to the right of the article online. CMHC is community mental health center. MH is mental health. PTSD is post-traumatic stress disorder. SSDI is Social Security Disability Insurance.

# For people with disabilities, employment serves many personal, societal, and governmental goals.

Individual placement and support has the potential for cost savings to the federal government. When Social Security disability beneficiaries are employed, they pay payroll taxes, and those on Supplemental Security Income (SSI) might receive smaller payments. However, because few people leave Social Security Disability Insurance (SSDI) rolls after gaining employment,<sup>16</sup> Social Security Administration payments are not substantially reduced in the long term, for reasons discussed below.

**DISABILITY POLICIES** The Social Security Administration administers two programs for disabled people. SSDI is available to people who have substantial employment histories, and SSI is available to those who have little or no employment history. In 2014, 9.4 million working-age adults (ages 18–64) received SSDI benefits,<sup>21</sup> and payments reached \$141.7 billion.<sup>22</sup> The SSDI Trust Fund is approaching insolvency, with Social Security Trustees estimating in 2014 that it would be insolvent in 2016.<sup>23</sup> In addition, 4.9 million working-age adults received SSI benefits in 2014 (including 1.4 million who also received SSDI).<sup>21</sup> Until recently, people with psychiatric impairments have been the most rapidly growing subgroup of Social Security disability beneficiaries (for both SSDI and SSI). The proportion of new SSDI beneficiaries with a primary disability of mental illness increased from 2 percent in 1978 to nearly 30 percent in 2005, while the proportion of existing SSI beneficiaries with a primary disability of mental illness increased from 24 percent in 1987 to 36 percent in 2005.<sup>24</sup> Since 2005 the number of SSDI beneficiaries with a primary disability of mental illness increased from 1,862,618 to 2,410,837 in 2014, but the entire SSDI population increased correspondingly, so the proportion with mental illness has remained stable.<sup>25</sup>

Social Security disability programs involve a host of disincentives for employment, starting with the requirement of extended separation

from the workforce as the first step in eligibility. Other disincentives include fear of losing monthly benefit payments and health insurance and unrealistic income replacement formulas (for example, a person on SSDI is likely to lose disability benefits if employment earnings exceed specified limits).<sup>26</sup>

Although people with psychiatric disabilities are the largest working-age (ages 18–50) subgroup of SSDI beneficiaries,<sup>25</sup> mental health concerns have never been in the mainstream of disability policies, which were designed for people with permanent impairments or lethal illnesses, not for those with fluctuating, gradually improving illnesses that respond to treatment, as is the case for most psychiatric disorders. Furthermore, although Social Security policies do allow for continuing disability reviews, few of the cases slated for redetermination are ever reevaluated, so very few beneficiaries leave the rolls.<sup>27</sup>

Changing disability policies, for example, by gradual reduction of SSDI payments in relation to amount of employment, could improve beneficiaries' chances to leave the disability rolls. In the Netherlands, legislation that shifted financial responsibility to employers for the first two years of short-term disability payments has decreased the number of people receiving long-term disability benefits.<sup>28</sup> In the United States, many efforts to help Social Security disability beneficiaries achieve employment goals and greater self-sufficiency have increased social inclusion through employment but have not reduced dependence on disability benefits. For example, the Mental Health Treatment Study,<sup>29</sup> the Benefit Offset National Demonstration,<sup>30</sup> the Accelerated Benefits Demonstration,<sup>31</sup> and the Youth Transition Demonstration<sup>32</sup> each exhibited positive impacts on beneficiaries, but none of the programs studied, including individual placement and support, reduced reliance on disability benefits.

## Individual Placement And Support As An Early Intervention

**RESEARCH** Over the past decade, most early-intervention mental health teams have included individual placement and support specialists, resulting in large improvements in competitive employment outcomes.<sup>33–35</sup> Three of the twenty-three randomized controlled studies of individual placement and support targeted early intervention and showed differences in competitive employment rates at follow-up from 24 percent to 55 percent favoring individual placement and support (Exhibit 1).<sup>36–38</sup> Several nonexperimental early intervention programs that included individual placement and support have also dem-

onstrated large increases in competitive employment.<sup>33,39</sup>

Researchers hypothesize that early intervention services will change the course of serious mental illness and divert young adults from the disability system,<sup>40</sup> but few empirical studies have addressed this hypothesis. Two international studies demonstrated that early intervention services (including individual placement and support) reduced dependence on disability benefits. In a Swedish study, 38 percent of participants with a first episode of psychosis receiving early intervention were on disability allowance at three-year follow-up, significantly less than 59 percent for historical controls.<sup>41</sup> In a six-month controlled trial in Australia, among clients with a first episode of psychosis enrolled in an early intervention program, the percentage of individual placement and support clients on welfare benefits decreased 25 percent, while the percentage of control group clients receiving welfare benefits did not change.<sup>36</sup>

**DISABILITY POLICIES** Social Security disability policies do not currently address prevention. Some people with serious mental illnesses could, in theory, avoid disability if they were able to obtain health insurance, temporary financial assistance, and help returning to work after they become ill. Recently, the Centers for Medicare and Medicaid Services signaled support for state efforts to develop early intervention programs for people experiencing first-episode psychosis, and the Substance Abuse and Mental Health Services Administration (SAMHSA) added funds to state block grants to implement these services.

Nevertheless, preventing psychiatric disability in the United States remains a theory because no early-intervention studies have yet demonstrated reduced disability enrollment. In 2015 the Social Security Administration focused on prevention in designing the Early Intervention Mental Health Demonstration.<sup>42</sup> The demonstration is intended to test the hypothesis that evidence-based mental health and individual placement and support services will enable individuals who have had a mental health disorder episode but have been denied in an initial application for benefits to improve their mental health status, achieve competitive employment, and reduce the need for disability benefits.

### Barriers And Enablers For Expanding Individual Placement And Support

Despite strong evidence regarding the effectiveness of individual placement and support, national surveys of state mental health leaders indicate that only about 2 percent of adults

## Social Security disability programs involve a host of disincentives for employment.

with serious mental illnesses have access to this evidence-based service.<sup>43</sup> Several factors deter or facilitate scaling up. Individual placement and support is a team intervention, with employment specialists joining a clinical team in a community mental health program. To deliver individual placement and support services, the sponsoring organization must provide team-based care, hire and train staff, establish work procedures, and secure payment for their services.

While each of these factors has in the past been a barrier to expansion of individual placement and support, all except for payment have been greatly reduced over the past decade. Training for individual placement and support specialists and organizations that would provide these services is available from the national individual placement and support learning community.<sup>17,44</sup> Regional and state-level technical assistance centers that provide hands-on assistance have facilitated individual placement and support expansion, but only a few states (for example, Kansas, Maryland, New York, Ohio, Oregon, and Vermont) have such state-supported resources.

A 1999 US Supreme Court case—the decision in *Olmstead v. L.C.*—has also promoted the expansion of individual placement and support. Drawing on the Americans with Disabilities Act of 1990, the Court ruled that states must provide community services to enable people with disabilities to live in their own homes instead of in institutions or congregate facilities. This decision has also been interpreted to encompass full social inclusion, including individual placement and support. Subsequently, the Department of Justice has led successful class-action suits against numerous states to conform to this decision and provide statewide dissemination of individual placement and support.<sup>45</sup>

Momentum for implementing individual placement and support programs widely has grown,<sup>46</sup> but funding remains the most challenging barrier. No government agency at the national or state level has either the mandate or sufficient dedicated funding to provide individual

# 2%

#### Have access

Only about 2 percent of adults with serious mental illnesses have access to individual placement and support services.

# The federal government has recently taken several steps to encourage expansion of individual placement and support.

placement and support to even a significant minority of adults with serious mental illnesses. State (or county) mental health departments and local agencies have a broad mandate to serve the psychiatric disability population but do not generally focus on employment. The state offices of vocational rehabilitation emphasize employment but serve people with many different disabilities and have extremely limited funding; Medicaid has a broad health care mandate but generally offers limited support for employment services. Furthermore, private health insurance typically does not pay for employment services, so an unintended impact of the Affordable Care Act (ACA), at least in the short term, has been to limit access to employment services for young adults up to age twenty-six who remain on their parents' insurance policies and do not apply for Medicaid as a secondary insurer.<sup>47</sup>

According to a 2014 survey of 122 individual placement and support programs in thirteen states, programs typically funded individual placement and support with a combination of vocational rehabilitation payments, state and county sources, and Medicaid (used by 87 percent, 80 percent, and 66 percent of programs, respectively).<sup>44</sup> A small number of states have used the Social Security Administration's Ticket to Work program to help support individual placement and support providers. Eligible SSI beneficiaries can sign up and use their "ticket" (essentially a voucher) with enrolled rehabilitation providers. The provider is not reimbursed for services but can receive "milestone" payments based on the individual's earnings. Most mental health rehabilitation providers have not considered Ticket to Work a viable option because the ratio of administrative burden to milestone payments, in the absence of funding for core individual placement and support services, is insufficient. Several states, including New

York and Washington, have moved to ameliorate these challenges via statewide agreements with the Social Security Administration that greatly reduce provider paperwork. Nevertheless, the effectiveness and generalizability of these arrangements is not yet clear.

Medicaid is now the nation's largest source of funding for mental health care.<sup>48</sup> States have turned to Medicaid to pay for mental health care in large measure because the federal government pays 50–80 percent of the cost. Under the ACA, several Medicaid mechanisms can reimburse individual placement and support services, such as Medicaid's rehabilitation services option and the new home and community-based services option. These allow states to amend their Medicaid plans to provide individual placement and support services for individuals with serious mental illnesses. However, most states do not yet use these mechanisms to fund individual placement and support.

The federal government has recently taken several steps to encourage expansion of individual placement and support, such as specifically endorsing the use of Medicaid to pay for individual placement and support services in early psychosis programs.<sup>49</sup> In 2014 SAMHSA initiated a new competitive grant program (Supported Employment Program) that resulted in awards to seven states. Funded states are expected to develop a statewide network of sites as well as in-state capabilities for training and evaluation, following the national individual placement and support learning community model. But the essential funding problem remains: Pursuing waivers and other mechanisms and combining payment sources to fund individual placement and support has been too complicated for most mental health centers, especially in the context of other health care changes and uncertainties.

## Conclusion

Employment is a key determinant and indicator of health for everyone. The majority of people with serious mental illnesses are unemployed but desire to work and, with the help of individual placement and support, are able to gain competitive employment, at least part time, thereby improving personal and societal goals but not enabling them to leave disability rolls.

Scaling up individual placement and support services to expand employment for people with serious mental illnesses has steadily gained momentum, but the major barrier remains the lack of a simple funding stream. The time to solve this problem and expand individual placement and support services is overdue.

Because those who are already in Social

Security disability programs rarely leave the disability rolls, even when employed, attention has shifted to prevention through early intervention programs that provide evidence-based mental health and individual placement and support services. Early intervention services and employment may forestall the need for disability payments by enabling people with mental illnesses

to earn money, become more independent, and improve their lives. When employed, they may also use fewer health services, although the long-term impact on government expenses remains unclear. The Social Security Administration's Early Intervention Mental Health Demonstration<sup>42</sup> will test the disability prevention theory, with results expected in 2022. ■

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