Individual placement and support

Clinical Policy ID: CCP.4043

Recent review date: ~~1/2023~~9/2024

Next review date: ~~5/2024~~1/2026~~12/2025~~

Policy contains: Employment support; individual placement and support; serious mental illness; schizophrenia; vocational rehabilitation.

AmeriHealth Caritas Louisiana has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Louisiana's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered, on a case by case basis, by AmeriHealth Caritas Louisiana when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Louisiana's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Louisiana's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Louisiana will update its clinical policies as necessary. AmeriHealth Caritas Louisiana's clinical policies are not guarantees of payment.

Coverage policy

Individual Placement and Support (IPS) refers to the evidence-based practice of supported employment for members with mental illness. IPS helps members living with mental health conditions work at regular jobs of their choosing that exist in the open labor market and pay the same as others in a similar position, including part-time and full-time jobs. IPS helps people explore the world of work at a pace that is right for the member. Based on member's interests, IPS builds relationships with employers to learn about the employers' needs in order to identify qualified job candidates.

The job search is based on individual preferences, strengths, and work experiences, not on a pool of jobs that are readily available or the IPS specialist's judgment. Job seekers indicate preferences for job type, work hours, and types of job supports. Job supports are individualized based on the needs of the member and what will promote a positive work experience. IPS offers help with job changes career development and career advancement, including additional schooling and training, assistance with education, a more desirable job, or more preferred job duties. The majority of IPS services must be provided in the community.

IPS provides competitive job options that have permanent status rather than temporary or time-limited status. Competitive jobs pay at least minimum wage, are jobs that anyone can apply for, and are not set aside for people with disabilities. IPS offers to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held. Some people try several jobs before finding employment they like. Each job is viewed as a positive learning experience. If a job is a poor match, an

IPS specialist offers to help the member find a new job based upon lessons learned. IPS follows the philosophy that all choices and decisions about work, further schooling, technical training, and support are individualized based on the member's preferences, strengths, and experiences. In IPS, members are encouraged to be as independent as possible and IPS specialists offer support as needed.

Evaluation of the Evidence Based Practice

Research has demonstrated that this method of supported employment is the most effective approach for helping people with serious mental illness who want to work in regular jobs. Evidence to support IPS can be found at https://ipsworks.org/index.php/evidence-for-ips/.

Components

Each IPS specialist carries out all phases of employment service, including intake, engagement, assessment, job placement, job coaching, and follow-along supports before step down to less intensive employment support from another mental health practitioner.

The IPS model is based on an integrated team approach which includes the following:

1. IPS programs are staffed by IPS specialists, who meet frequently with the mental health treatment team to integrate IPS services with mental health treatment. IPS specialists with a caseload of nine (9) or less members participate in bi-weekly client-based individual or group supervision and mental health treatment team meetings for each team to which they are assigned. Once IPS specialists have a caseload of ten (10) or more members, they participate in weekly client-based individual or group supervision, and mental health treatment team meetings for each team to which they are assigned:

    a. The employment unit has weekly client-based individual or group supervision following the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed;

    b. IPS specialists attach to one (1) or two (2) mental health treatment teams, from which at least 90% of the employment specialist's caseload is comprised; and

    c. IPS specialists actively participate in weekly mental health treatment team meetings (not replaced by administrative meetings) that discuss individual members and their employment goals with shared decision-making.

2. Members are not asked to complete vocational evaluations (e.g., paper and pencil vocational tests, interest tests, and work samples), situational assessments (such as short-term work experiences), prevocational groups, volunteer jobs, short-term sheltered work experiences, or other types of assessment in order to receive assistance obtaining a competitive job;

3. Initial vocational assessment occurs over 2-3 sessions and is updated with information from work experiences in competitive jobs and aims at problem solving using environmental assessments and consideration of reasonable accommodations, such as, but not limited to, American Disability Act (ADA) requirements to encourage an atmosphere of productivity considering the member's diagnosis;

4. A vocational profile form that includes information about preferences, experiences, skills, current adjustment, strengths, personal contacts, etc., is updated with each new job experience. Sources of information include the member, treatment team, clinical records, and with the member's permission,

from family members and previous employers. The vocational assessment (referred to as the "career profile") leads to individualized employment and education planning. The career profile is updated with each new employment and education experience. The purpose is not to determine employability, but to learn what the member enjoys, skills and experiences, and what will help the member achieve goals. Initial employment assessment occurs within 30 days after program entry;

5. An individualized job search plan is developed and updated with information from the vocational assessment/profile form and new job/educational experiences;

6. IPS specialists systematically visit employers, who are selected based on the job seeker's preferences, to learn about their business needs and hiring preferences. Each IPS specialist makes at least 6 face-to-face employer contacts per week on behalf of members looking for work. An employer contact is counted even when an employment specialist meets the same employer more than one time in a week, and when the member is present or not present. Member-specific and generic contacts are included. IPS specialists use a weekly tracking form to document employer contacts;

7. IPS programs use a rapid job search approach to help job seekers obtain jobs rather than assessments, training, and counseling. IPS specialists help members look for jobs soon after entering the program instead of requiring pre-employment assessment and training or intermediate work experiences, such as prevocational work units, short-term jobs to assess skills, transitional employment, agency-run businesses or sheltered workshops. The first face to face contact with the employer by the member or the IPS specialist occurs within 30 days;

8. IPS specialists ensure that members are offered comprehensive and personalized benefits planning, including information about how work may affect their disability and government benefits. The purpose is to help members make informed decisions how working and developing a career may be the quickest way to avert poverty or dependence on benefits. All members are offered assistance in obtaining comprehensive, individualized work incentives (benefits) planning before starting a new job and assistance accessing work incentives planning thereafter when making decisions about changes in work hours and pay. Work incentives planning includes SSA benefits, medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits, and any other sources of income;

9. Job supports are individualized and continue for as long as each worker wants and needs the support. Members receive different types of support for working a job that are based on the job, member preferences, work history, needs, etc. Once members obtain employment, the IPS specialist and staff from the mental health treatment team provide support as long as members want and benefit from the assistance. The goal is for each member to work as independently as possible and transition off the IPS caseload when the member is comfortable and successful in their work life;

   a. IPS specialists have face-to-face contact within one (1) week before starting a job, within three (3) days after starting a job, weekly for the first month, and documented efforts to meet with members at least monthly for a year or more, on average, after working steadily, and desired by members; and

   b. Members are transitioned to step down job supports from a mental health worker following steady employment. IPS specialists contact members within three (3) days of learning about the job loss. IPS specialists also provide employer support (e.g., educational information, job accommodations) at a member's request.

10. Service termination is not based on missed appointments or fixed time limits:

a. Engagement and outreach attempts made by integrated team members are systematically documented, including multiple home/community visits, coordinated visits by IPS specialist with integrated team member, and contacts with family, when applicable; and

b. Once it is clear that the member no longer wants to work or continue with IPS services, the IPS specialist stops outreach.

Eligibility Criteria

AmeriHealth Caritas-eligible members who meet medical necessity criteria in accordance with LAC 50:I.1101 may receive IPS when recommended by an LMHP or physician within their scope of practice. Members must be:

1. At least 21 years of age; and

2. Transitioned from a nursing facility or been diverted from nursing facility level of care through the My Choice Louisiana program.

All members meeting the above criteria who are interested in working have access to this service. Members are not excluded on the basis of job readiness, diagnoses, symptoms, substance use history, substance abuse, mental health symptoms, history of violent behavior, cognition impairment, treatment non-adherence, homelessness, work history, psychiatric hospitalizations, homelessness, level of disability, legal system involvement, or personal presentation.

Service Utilization

Services are subject to prior authorization. Providers shall submit sufficient documentation to determine medical necessity. Failure to do so may result in a partial or non-authorization for services. Services may be provided at a facility or in the community as outlined in the treatment plan.

Service Delivery

There shall be member involvement throughout the planning and delivery of services. Services shall be:

1. Delivered in a culturally and linguistically competent manner;

2. Respectful of the member receiving services;

3. Appropriate to members of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and

4. Appropriate for age, development, and education.

Any licensed practitioner providing behavioral health services must operate within their license and scope of practice. Staff Ratios One (1) full time employment specialist to 20 active members. Allowed Provider Types and Specialties PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health.

Allowed Modes of Delivery

1. Individual;

2. On-site; and

3. Off-site.

Provider Responsibilities

Supervision

The IPS unit has weekly member-based individual or group supervision following the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed. When there is good fidelity to this item, the IPS supervisor meets weekly with all the IPS specialists as a group to review client employment goals and progress towards achieving those goals. See Components section number 1 for information regarding caseload and supervision.

IPS specialists share ideas to help members meet their goals. IPS specialists also share job leads during the meeting and occasionally introduce each other to employers. IPS specialists have discrete caseloads but provide back up and support for other IPS specialists as needed. IPS specialists' skills are developed and improved through outcome-based supervision.

All five (5) key roles of the IPS supervisor are present as follows:

1. One full-time (FTE) supervisor is responsible for no more than 10 IPS specialists. The supervisor does not have other supervisory responsibilities. (IPS supervisors supervising fewer than ten (10) IPS specialists may spend a percentage of time on other supervisory activities on a prorated basis. For example, an IPS supervisor responsible for 4 IPS specialists may be devoted to IPS supervision half time);

2. Supervisor conducts weekly supervision designed to review member situations and identify new strategies and ideas to help members with their work lives. Either individual or group supervision is sufficient. New IPS specialists often benefit from weekly individual supervision while experienced IPS specialists often appreciate the support of individual supervision at least once or twice monthly;

3. Supervisor communicates with mental health team leaders to ensure that services are integrated, to problem-solve programmatic issues, (such as referral issues or transfer of follow-along to mental health workers), and to be a champion for the value of work. Supervisor attends a meeting for each mental health treatment team on a quarterly basis;

4. Supervisor accompanies IPS specialists, who are new or having difficulty with job development, in the field monthly to improve skills by observing, modeling, and giving feedback on skills, e.g., meeting employers for job development; and

5. Supervisor reviews current member outcomes (e.g., job starts, number and percent of people working, number/percent of people in education programs, etc.) with IPS specialists and sets goals to improve program performance at least quarterly.

Provider Qualifications

IPS must be provided only under the administrative oversight of licensed and accredited local governing entities (LGEs). Providers must meet state and federal requirements for providing IPS.

Agency

To provide IPS, agencies must meet the following requirements:

1. Be licensed – pursuant to La. R.S. 40:2151, et. seq.;

2. Be Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification to the managed care entities with which the agency contracts or is being reimbursed;

NOTE: Agencies must apply for accreditation and pay accreditation fees prior to being contracted and reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. Agencies must attain full accreditation within eighteen (18) months of the initial accreditation application date.

3. Arrange for and maintain documentation that prior to employment (or contracting, volunteering, or as required by law) individuals pass criminal background checks, including sexual offender registry checks, in accordance with all of the following:

a. La. R.S. 40:1203.1 et seq. associated with criminal background checks of un-licensed workers providing patient care;

b. La. R.S. 15:587, as applicable; and

c. Any other applicable state or federal law.

4. Shall not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations shall not be utilized on an employment, contract nor volunteer basis:

a. Criminal background checks performed over ninety (90) days prior to the date of employment will not be accepted as meeting the criminal background check requirement; and

b. Results of criminal background checks are to be maintained in the individual's personnel record. Evidence of the individual passing the criminal background check requirements must be maintained on file with the provider agency;

5. Must review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and non-licensed staff, interns and contractors;

a. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General; and

b. The provider is prohibited from knowingly employing, contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare

Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General.

6. Maintain results that checks have been completed. The OIG maintains the LEIE on the OIG website (https://exclusions.oig.hhs.gov) and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch;

7. Arranges for and maintain documentation that all employment specialists, prior to employment, are free from Tuberculosis (TB) in a communicable state as defined by the LAC 51:II.Chapter 5 to reduce the risk of such infections in members and staff. Results from testing performed over thirty (30) days prior to date of employment will not be accepted as meeting this requirement;

8. Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use ~~(See Appendix D)~~;

9. Maintain documentation that all staff providing direct care, who are required to complete First Aid and cardiopulmonary resuscitation (CPR), complete American Heart Association (AHA) recognized training within ninety (90) days of hire, which shall be renewed within a time period recommended by the AHA (See Appendix D);

10. Maintain documentation of verification of completion of required trainings and certifications for all IPS staff;

11. Ensure and maintain documentation that all persons employed by the organization complete training in a state recognized Crisis Intervention curriculum prior to handling or managing crisis responses, which shall be updated annually. (See Appendix D for list of trainings); and

12. Has a National Provider Identification (NPI) number, and must include the agency NPI number and the NPI number of the individual rendering IPS on its behalf on all claims for Medicaid reimbursement, where applicable.

IPS Fidelity Standards

IPS teams must meet fidelity standards as evidenced by the Supported Employment Fidelity Review Manual found at https://ipsworks.org/wp-content/uploads/2019/12/Final-Fidelity-Manual-Fourth-Edition-112619.pdf. When an agency has more than one IPS team, separate reviews are scheduled for each team. A team consists of a group of IPS specialists who report to one supervisor.

New Teams

New IPS teams must:

1. Submit documentation to **AmeriHealth Caritas** for contracting purposes including evidence of fidelity to the model including findings of self-evaluation using the IPS Fidelity Scale (https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-Scale-Eng1.pdf);

   a. The self-evaluation must reflect a baseline score in order to be eligible to provide **Plan** services to members.

2. Undergo a fidelity review using the IPS Fidelity Scale by an **AmeriHealth Caritas**-identified third party within six (6) months of implementation:

   a. This review must reflect continued improvement toward the desired score of 100 (good fidelity);

b. The team will implement an AmeriHealth Caritas-approved corrective action plan immediately for any individual IPS Fidelity Scale criterion that rates a one (1), two (2), or three (3);

c. This plan should be implemented within thirty (30) days of findings or sooner as determined necessary by AmeriHealth Caritas to mitigate health and safety issues for members; and

d. Fidelity is tested every six (6) months for a new program until a score of 100 is reached.

Existing teams

Once a new team achieves a fidelity review score of 100 or above, that team is considered an existing team and must:

1. Participate in fidelity reviews using the IPS Fidelity Scale conducted by AmeriHealth Caritas or designee at least annually (every twelve (12) months) or more frequently as prescribed by AmeriHealth Caritas; and

2. Maintain a minimum score of 100 and above on the IPS Fidelity Scale or the team will implement an AmeriHealth Caritas-approved corrective action plan and achieve a minimum score of 100 on the IPS Fidelity Scale within six (6) months in order to maintain the ability to accept new clients.

If a 115 to 125 on the IPS Fidelity Scale is achieved, the team will be deemed as operating with "exceptional practice." AmeriHealth Caritas may grant extensions of twenty-four (24) month intervals between fidelity reviews for teams operating with "exceptional practice."

Teams are considered to be operating below acceptable fidelity thresholds if they are achieving less than 100 on the IPS Fidelity Scale after implementing an AmeriHealth Caritas approved corrective action plan for six (6) months will forfeit the ability to accept new members though they can continue to work with existing members as long as there are no health and safety violations with operations as determined by AmeriHealth Caritas or LDH. Teams shall implement an AmeriHealth Caritas-approved corrective action plan and undergo another fidelity review within six (6) months by AmeriHealth Caritas or designee. If the team achieves at least 100 on the IPS Fidelity Scale in subsequent review, the team can resume accepting new referrals.

Staff

Individuals providing IPS must operate under the administrative oversight of a licensed and accredited LGE. IPS Specialists must:

1. Complete continuing education in confidentiality requirements, Health Insurance Portability and Accountability Act (HIPAA) requirements and mandated reporting;

2. Have a satisfactory completion of criminal background checks pursuant to the, La R.S. 40:1203.1 et seq., La R.S. 15:587 (as applicable), and any applicable state or federal law or regulation;

3. Not be excluded from participation in the AmeriHealth Caritas Program by Louisiana Medicaid or the Department of Health and Human Services Office of Inspector General;

4. Not have a finding on the Louisiana State Adverse Action List;

5. Pass a TB test prior to employment in accordance with the LAC 51:II.Chapter 5; OR be free from Tuberculosis (TB) in a communicable state as defined by the LAC 51:II.Chapter 5;

6. Pass drug screening tests as required by provider agency's policies and procedures;

7. Complete American Heart Association (AHA) recognized First Aid and CPR training. Psychiatrists, APRNs, PAs, RNs and LPNs are exempt from this training (See Appendix D); and

8. Non-licensed direct care staff are required to complete a basic clinical competency training program approved by OBH prior to providing the service. (Refer to Appendix D).

Staffing Requirements

At least one dedicated IPS specialist and an IPS supervisor comprise the employment unit. Peer specialists are members of some IPS teams, who share their own experiences to inspire others to work and build careers.

The requirements for IPS specialist and IPS supervisors are indicated as follows:

IPS Specialist

1. High school diploma is required;

2. Two years post high school experience in employment;

3. One year experience working with people with severe mental illness;

4. Successfully completed IPS training prior to providing services; and

5. Have current IPS Certification or achieve certification within two (2) years.

IPS Peer Specialist (Optional staff, but recommended)

1. Must be a Peer Support Specialist as defined in Section 2.3: Outpatient Services – Peer Support Services; and

2. Have current IPS Certification or achieve certification within four (4) years.

IPS Supervisor

1. Master's degree in rehabilitation counseling or mental health field is preferred; Bachelor's degree is required. Previous experience as an employment specialist is necessary;

2. Experience working with people with severe mental illness;

3. At least one (1) year experience in employment services;

4. Successfully completed IPS training prior to providing services; and

5. Have current IPS certification, or achieve certification within two (2) years.

IPS Training and Recertification

IPS staff must obtain IPS Certification (CIPS) within two (2) years of employment as an IPS specialist and maintain certification thereafter. Information on IPS Certification and trainings are available at www.IPSworks.org.

Limitations/Exclusions

1. IPS services shall not duplicate any other AmeriHealth Caritas Plan service or service otherwise available to the member at no cost;

2. IPS services are provided to members who are not served by the Louisiana Workforce Commission's Louisiana Rehabilitation Services (LRS) organization and need more intensive supports;

3. IPS services may not be provided if the service is otherwise available under a program funded under the Rehabilitation Act of 1973; and

4. Incentive payments, subsidies, or unrelated vocational training expenses may not be billed such as but not limited to: incentive payments made to an employer to encourage or subsidize the employer's participation in a IPS program; payments that are passed through to users of IPS programs; or payments for vocational training that is not directly related to a member's IPS program.

Billing

IPS service is a bundled rate including all of the components outlined above in a month.

~~Individual placement and support is clinically proven and, therefore, medically necessary for members who meet all of the following medical necessity criteria in accordance with Louisiana Administrative Code Title 50: Part I, Section1101, when recommended by a Louisiana mental health practitioner or physician within their scope of practice:~~

- ~~At least 21 years of age.~~
- ~~Have transitioned from a nursing facility or been diverted from nursing facility level of care through the My Choice Louisiana program.~~
- ~~Interested in obtaining competitive employment. Members are not excluded on the basis of job readiness, diagnoses, symptoms, substance use history, substance abuse, mental health symptoms, history of violent behavior, cognition impairment, treatment non-adherence, homelessness, work history, psychiatric hospitalizations, homelessness, level of disability, legal system involvement, or personal presentation (IPS Employment Center, 2022).~~

~~Services are subject to prior authorization. Providers shall submit sufficient documentation to determine medical necessity. Failure to do so may result in a partial or nonauthorization for services. Services may be provided at a facility or in the community as outlined in the treatment plan.~~

~~Continuation criteria~~

~~Individual placement and support services are provided in accordance with service delivery and state and federal provider requirements as outlined in the Louisiana Department of Behavioral Health Services Manual, Section 2.3: Outpatient Services - Individual Placement and Support (2022), and individual placement and support fidelity standards as outlined in the Individual Placement and Support Employment Center Supported Employment Fidelity Review Manual (Becker, 2019).~~

~~Individual placement and support must be provided only under the administrative oversight of licensed and accredited local governing entities and Assertive Community Treatment agencies.~~

~~Service termination criteria~~

~~Service termination is based on the member's desire to no longer work or continue with individual placement and support services, not based on missed appointments or fixed time limits.~~

~~Engagement and outreach attempts made by integrated team members are systematically documented, including multiple home/community visits, coordinated visits by the individual placement and support specialist with the integrated team member, and contacts with family, when applicable.~~

~~Limitations~~

Individual placement and support services shall not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost.
Individual placement and support service is a bundled rate including all of the components outlined above in a month.
Alternative covered services (subject to Plan benefit)
Prevocational training.
Educational services.

Background

Approximately 21% (52.9 million) of U.S. adults aged 18 or older live with a mental illness, and an estimated subset of 5.6% (14.2 million) live with the more severe form of serious mental illness (Substance Abuse and Mental Health Services Administration, 2020). Among those who experience disability due to serious mental illness, the burden of mental illness can be acutely felt emotionally, socially, and economically.

Federal regulation defines a serious mental illness as a condition that meets specific requirements for diagnosis, level of impairment, and duration of illness (Substance Abuse and Mental Health Services Administration, 2016):

- Patient is age 18 or older.
- Patient has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the Diagnostic and Statistical Manual of Mental Disorders — Fifth Edition criteria (American Psychiatric Association, 2022). Excluded are
    - Substance use disorders and developmental disorders, unless they occur with a diagnosable serious mental illness.
    - Dementia, including Alzheimer's disease, and mental disorders due to a general medical condition.
    - The disorder has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities: activities of daily living; interpersonal functioning; concentration, persistence, and pace; and adaptation to change.

The majority of individuals meeting these criteria are diagnosed with schizophrenia, schizoaffective disorder, psychotic disorders, major depressive disorders, bipolar disorders, and borderline personality disorder (Substance Abuse and Mental Health Services Administration, 2016). Anxiety disorders or eating disorders may also meet these criteria. In addition, states may include specific diagnoses.

Employment is a critical social determinant of health, as it provides a source of income, health insurance coverage, social connections, and sense of pride (National Alliance on Mental Illness, 2022). Most adults with serious mental illness want to work and can succeed with appropriate supports, but fewer than 7% of adults with schizophrenia who receive community mental health services are competitively employed. Competitive employment refers to a regular community job open to any applicant, pays a comparable wage to all who perform the same work (at least minimum wage), is integrated in the workplace, and has the same supervisory arrangements and conditions for all workers.

Supported employment programs assist people with mental illness to find and maintain competitive employment and earn higher wages (National Alliance on Mental Illness, 2022). The central tenet of supported employment programs is that people with mental illness who want to work can be placed in a job consistent with their interests,

skills, abilities, and preferences, and receive appropriate job support and mental health treatment concurrently. Supported employment programs differ from traditional vocational rehabilitation programs that emphasize training first with vocational groups, workshops, and counseling, followed by placement in sheltered and transitional employment rather than in a competitive employment setting (Marino and Dixon, 2014). Supported educational services are also an option for individuals whose goals include educational advancement prior to pursuit of employment.

Individual placement and support

Individual placement and support is a supported employment model aimed at helping adults with serious mental illness obtain a competitive job quickly, without extended preparation, and maintain the job, with supervision if needed (IPS Employment Center, 2022). The individual placement and support model was developed in the United States in the 1990s as an individualized employment service component of community mental health delivery. In this context, work rehabilitation is a desired treatment outcome, and individual placement and support employment specialists are integral to the mental health treatment team.

Individual placement and support comprises eight fundamental principles (IPS Employment Center, 2022):

- Obtaining competitive employment is the goal, with no artificial time limits imposed by the social service agency.
- Everyone who wants competitive employment is eligible, regardless of readiness, diagnosis, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.
- Services are based on job seeker's preferences and choices rather than the employment specialist's and supervisor's judgments.
- Rapid job placement is prioritized to help job seekers obtain jobs rather than assessments, training, and counseling. The first face-to-face contact with the employer occurs within 30 days.
- Mental health treatment teams are integrated to include employment specialists.
- Personalized benefits counseling is provided, related to the client's Social Security, AmeriHealth Caritas Louisiana, and other government entitlements.
- Employment specialists develop relationships with employers in the community according to client preferences.
- Individualized job support continues for as long as each worker wants and needs the support. Employment specialists have face-to-face contact at least monthly.

This individualized approach is gaining support for new populations other than those with serious mental illness. A network of 25 states and regions is participating in a learning community across states and regions devoted to sharing ideas for how to fund and expand individual placement and support services (IPS Employment Center, 2022; Pogue, 2021).Not applicable.

Findings

The American Psychiatric Association practice guideline (2021) recommends supported employment services for patients with schizophrenia. Services should be offered to anyone who is interested, with no exclusion criteria for participation. The harms associated with supported employment are not well delineated but are likely to be small. A significant number of individuals may be interested in supported employment, but it may not be readily

available to them, representing an area of unmet need. The majority of studies of supported employment involve the individual placement and support model.

The evidence from randomized controlled trials establishes individual placement and support as an effective vocational rehabilitation model for obtaining and maintaining competitive employment for adults diagnosed with serious mental illness and veterans with posttraumatic stress disorder (Davis, 2018a, 2018b; Suijkerbuijk, 2017; Weld-Blundell, 2021). The effectiveness remained robust across levels of program fidelity standards and a range of economic, labor, and regulatory conditions (Metcalfe, 2018).

A Cochrane review analyzed 48 randomized controlled trials of interventions for obtaining and maintaining competitive employment in adults with serious mental illness (Suijkerbuijk, 2017). The interventions studied were high-fidelity and low-fidelity individual placement and support alone or combined with other interventions, prevocational training programs, transitional employment interventions, or psychiatric care only. Thirty trials studied individual placement and support alone, and 13 studied augmented individual placement and support. The overall quality of included studies were assessed as low to moderate.

The majority of studies took place in North American settings and were published from 2000 or later (Suijkerbuijk, 2017). The majority of participants were diagnosed with a psychotic disorder (schizophrenia, schizoaffective, or other psychotic disorders). Most were unemployed at baseline but had worked within the previous five years, and were interested in competitive employment. The follow-up periods ranged from three months to five years. The primary outcome was the number or percentage of participants in competitive employment. Secondary outcomes were number of weeks in competitive employment, number of days to first competitive employment, percentage of participants who obtained noncompetitive employment, quality of life, mental health measures, and adverse events (dropouts and hospital admissions).

In terms of obtaining and maintaining employment, high-fidelity and low-fidelity individual placement and support and augmented individual placement and support were the most effective interventions for people with serious mental illness without increasing the risk of adverse events (Suijkerbuijk, 2017). While augmented supported employment appeared to be slightly more effective than supported employment alone, the differences were small using different analysis methods.

In another systematic review, 10 of 11 randomized controlled trials found a beneficial effect on open employment outcomes of individual placement and support alone or combined with other interventions compared to controls for participants with psychosocial disability (Weld-Blundell, 2021). Studies were assessed to have an overall moderate risk of bias.

Nonserious mental illness conditions

For populations with nonserious mental illness conditions (primarily nonpsychosis disorders), the strongest evidence supporting a benefit of individual placement and support examined veterans with chronic posttraumatic stress disorder in the Veterans Individual Placement and Support Toward Advancing Recovery Study, or VIP-STAR (Davis, 2018a, 2018b; ClinicalTrials.gov identifier: NCT01817712). This was a prospective, multisite, randomized clinical trial of unemployed veterans with posttraumatic stress disorder randomized to either individual placement and support (n = 271) or stepwise transitional work (n = 270).

More participants in the individual placement and support group achieved steady employment than in the transitional work group (105 [38.7%] versus 63 [23.3%], odds ratio 2.14, 95% confidence interval 1.46 to 3.14). Steady employment was defined as holding a competitive job for at least 50% of the 18-month follow-up period. A higher proportion of individual placement and support participants attained any competitive job (186 [68.6%] versus 154 [57.0%]; *P* = .005) and had higher cumulative earnings from competitive jobs (median [interquartile

range] $7,290 [$23,174] versus $1,886 [$17,167], *P* = .004). A systematic review by Bond (2019) confirmed these findings.

The evidence from individual randomized controlled trials, including systematic reviews of randomized controlled trials, is insufficient to support a clear benefit of individual placement and support for other indications (Bond, 2019; Fadyl, 2020; Hellström, 2021; Mueser, 2019; Probyn, 2021; Weld-Blundell, 2021). The systematic reviews often included results from the same individual trials. Therefore, although the results are encouraging, the evidence is limited to relatively few, small single-site trials of discrete populations that lack replication in independent studies. Review investigators cite concerns related to heterogeneity of interventions studied and outcome measures, and quality of the evidence reviewed.

For patients with first episode psychosis, one randomized controlled trial (Mueser, 2019) called the "Recovery After Initial Schizophrenia Episode-Early Treatment Program study" compared a specific integrated program, called "NAVIGATE," to usual community care involving 34 sites and 404 patients aged 15 to 40 years. The components of NAVIGATE included four interventions (individualized resiliency training, family education program, supported employment and education [individual placement and support], and personalized medication management) within staffing and structure of the NAVIGATE team. Preliminary findings suggest that, over two years, participants at NAVIGATE sites had substantially better clinical and psychosocial outcomes than those at community care sites. However, most of the sites demonstrated acceptable or higher levels of fidelity to overall service delivery implementation, but fidelity to supported employment and education implementation was the weakest, with multiple factors likely contributing to efficacy. The individual contribution of supported employment and education was unclear.

A systematic review (Bond, 2019) of participants who had psychiatric disorders other than serious mental illness (six randomized controlled trials), substance use disorders (two trials), and spinal cord injuries (one trial), found that competitive employment rates and other employment outcomes favored individual placement and support, but findings on symptom reduction and quality of life were inconsistent. Methodological limitations included small samples, major modifications to individual placement and support fidelity, and short follow-up periods. Further rigorous research and replication is needed on participants with anxiety, depression, substance use disorder, musculoskeletal or neurological conditions, or pain syndromes.

A systematic review of 13 randomized controlled trials and meta-analysis of six randomized controlled trials (n = 1,594) (Hellström, 2021) investigated the effect of individual placement and support according to three diagnoses of serious mental illness (schizophrenia, bipolar disorder, and major depression), and participants with either dual diagnoses (serious mental illness and substance use disorders) or forensic psychiatric conditions. The majority (74%) of participants were diagnosed with schizophrenia. Overall, individual placement and support was more effective than "services as usual" for obtaining competitive employment, working more hours and weeks, and returning to work faster for participants with schizophrenia ($P < .05$). Any vocational benefit was not statistically significant for the other diagnoses, likely due to lack of power and lower representation in the study populations.

For participants living with a mix of mild to moderate mental health conditions, a systematic review and meta-analysis (Fadyl, 2020) of seven controlled trials (n = 1,611) found recipients of individual placement and support modified for those who are not in intensive mental health treatment services were more likely to gain competitive employment than those who receive usual care (risk ratio 1.70, 95% confidence interval 1.23 to 2.34). The evidence was graded as very low quality with a high risk of bias.

Another systematic review (Probyn, 2021) found that individual placement and support for other nonserious mental illness conditions was confined to six small, individual randomized controlled trials assessed as having

~~moderate to high risk of bias. The results suggest individual placement and support may be more effective than control interventions for improving competitive employment in recipients with mental disorders and justice involvement; veterans with posttraumatic stress disorder; recipients of methadone treatment; veterans with spinal cord injury at 12 months and at 24 months; and young people not in employment, education, or training. The results did not show a competitive employment benefit for workers with musculoskeletal injuries, individuals with substance abuse, and formerly homeless people with mental illness.~~

~~In the systematic review by Weld-Blundell (2021), no randomized controlled trials met inclusion criteria for individuals with autism or intellectual disability.~~

~~In 2023, we added several systematic reviews and one randomized controlled trial to the policy. There is a growing body of evidence from systematic reviews and meta-analyses suggesting that individual placement and support improves employment outcomes for a broad range of target groups, with the strongest evidence supporting adults with serious mental illness. Currently, no policy changes are warranted.~~

~~A meta-analysis of 32 studies (n = 3,818 intervention group and 3,847 controls) analyzed the relative effectiveness of individual placement and support for different subgroups. The mean age of participants was 38.9 years (range 20.4 to 51.0 years). In line with previous findings, individual placement and support is relatively more effective for individuals with serious mental illness and schizophrenia spectrum disorder and a low symptom severity, and relatively less effective for individuals with major depressive disorder and common mental disorders and a higher symptom severity. Individual placement and support was equally effective after both short and long follow-up periods (less than or greater than 12 months, respectively) (de Winter, 2022).~~

~~These results extend to young adults of working age with different mental health conditions (Bond, 2022; Thompson, 2022). Authors of both analyses recommended additional well-controlled intervention studies that examine educational and longer-term outcomes for the young adult population.~~

~~A randomized controlled trial compared usual treatment with and without individual placement and support for adults with chronic pain in a tertiary pain center setting in Norway (Sveinsdottir, 2022). Usual treatment consisted of interdisciplinary pain treatment, regular follow-up, and information on services and resources for people in unemployment or work disability, self-help advice, pain management, and vocational rehabilitation resources. During 12-month follow-up, 52.8% in the individual placement support group and 38.9% in the usual treatment group had attained employment. The difference increased during 24-month follow-up but did not reach statistical significance. Larger randomized controlled trials are needed to draw clear conclusions about effectiveness in this population.~~

~~A systematic review of seven economic studies based on randomized clinical trial data, including two studies from the United States, found individual placement and support programs may be a cost-effective alternative to traditional vocational rehabilitation programs for adults with serious mental illness. In the United States, individual placement and support may cost the same or higher than traditional vocational rehabilitation, depending on the benefit measure used (Zheng, 2022).~~Not applicable.

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~~On November 2, 2022, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were "mental disorders/rehabilitation" (MeSH), "employment, supported" (MeSH), and "individual placement and support." We included the best available~~

evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Policy updates

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1/2023: Policy references updated.

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