



The Individual Placement and Support model of supported employment for people with mental illness who want to work in competitive settings

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Disclosure Statement

I have no actual or potential conflict of interest in relation to this presentation.

Why IPS?

- Most people with severe mental illness want to work, but few do

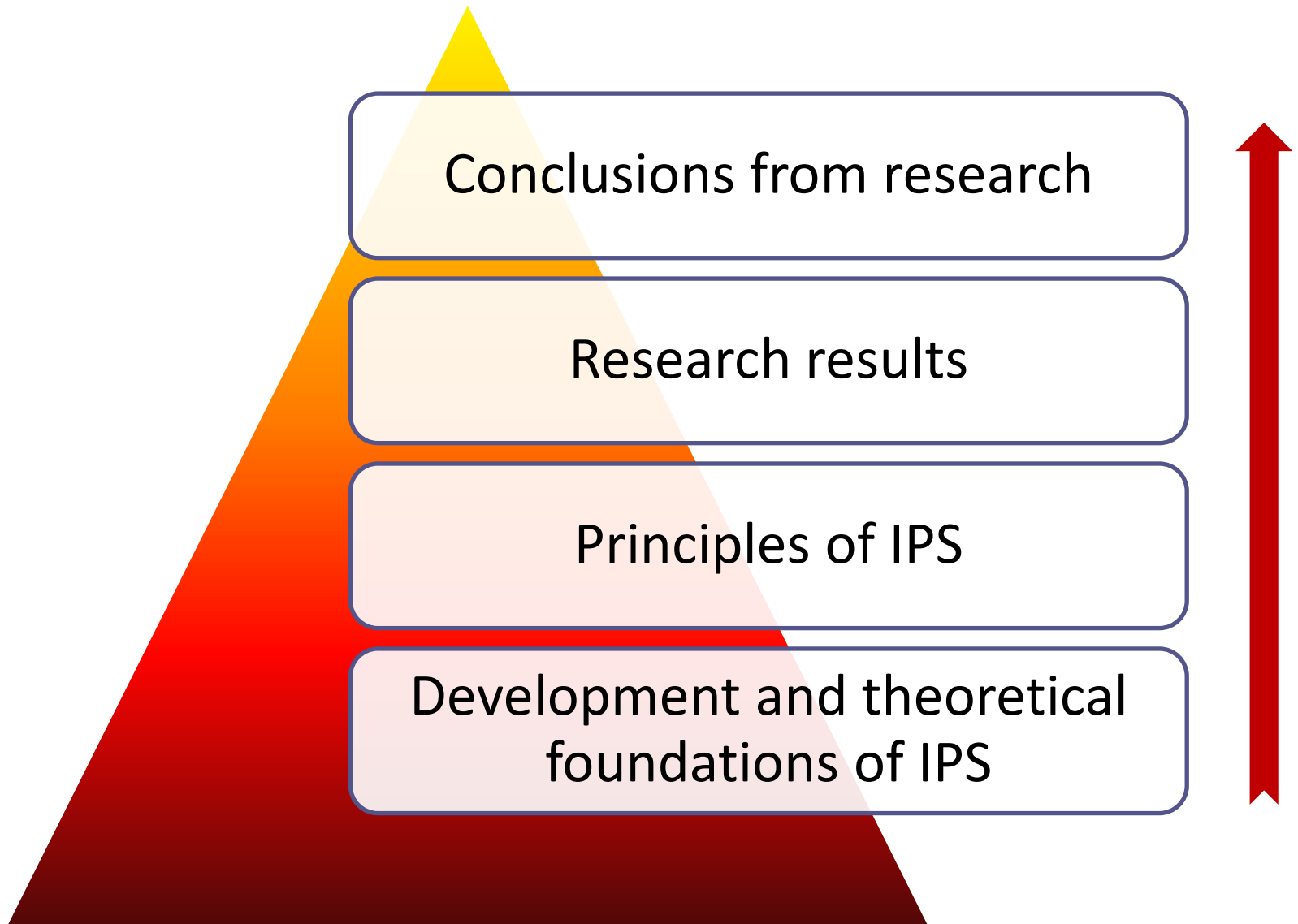


- Competitive work:
 - Better corresponds to their preferences
 - Favors social inclusion
- IPS is the model best supported by experimental evidence

Interest expressed in work in 6 studies

Study	Survey Population	
Rogers (1995)	statewide survey of people with mental illness	71%
Bedell (1998)	sheltered workshop participants	69%
Mueser (2001)	study of family intervention	61%
McQuilken (2003)	clubhouse members	55%
Frounfelker (2011)	clients with co-occurring substance use	72%
Ramsay (2011)	young adults experiencing early psychosis	78%
Source: Gary Bond	Mean across studies	68%

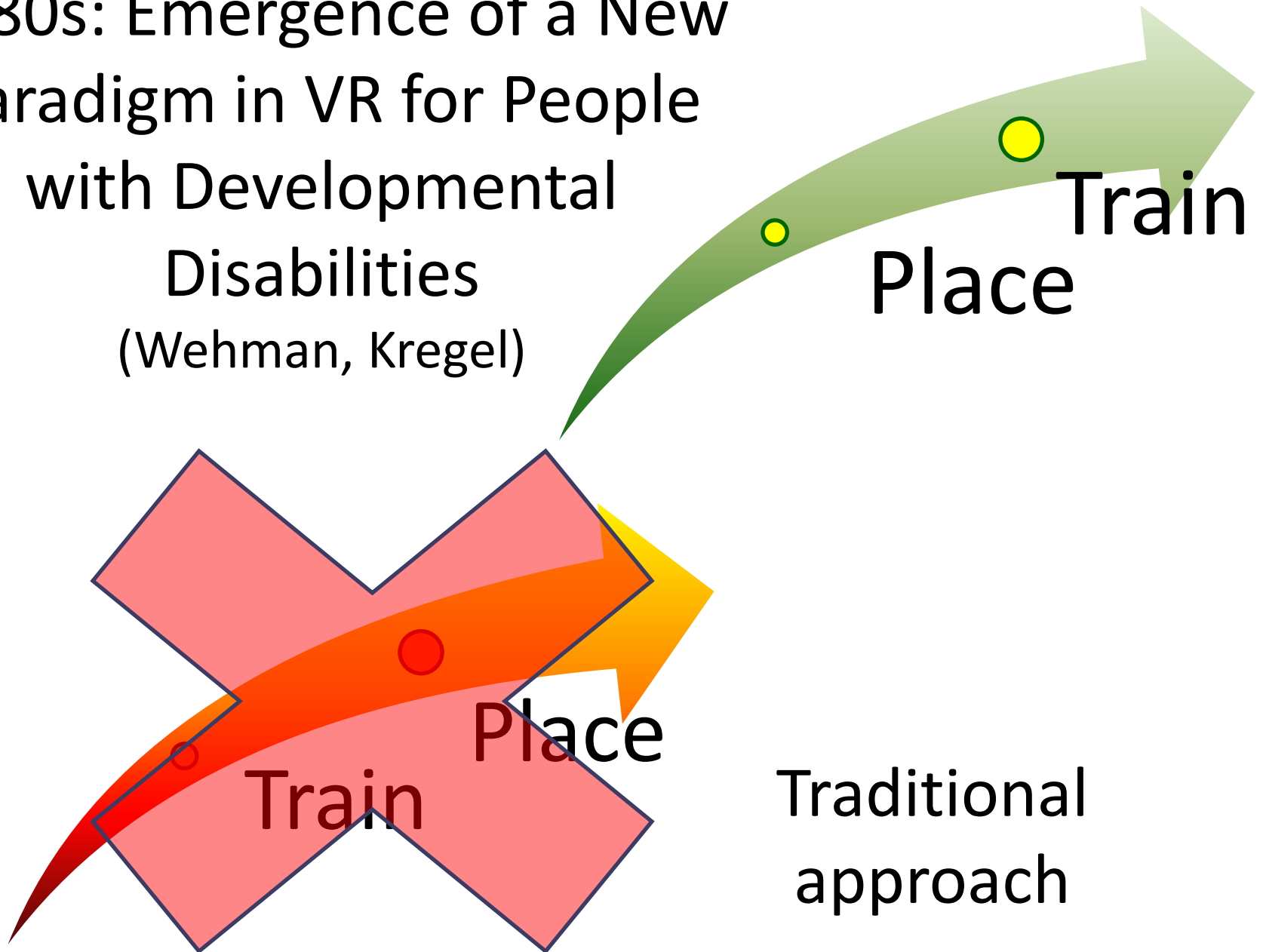
PLAN OF PRESENTATION



Development of IPS



1980s: Emergence of a New Paradigm in VR for People with Developmental Disabilities (Wehman, Kregel)



Assertive
Community
Treatment



*Idea of integrating
vocational and
clinical services*

*“Choose-get-keep” –
Emphasis on
respecting client
choice*

Traditional approaches involving
sheltered and/or transitional
settings



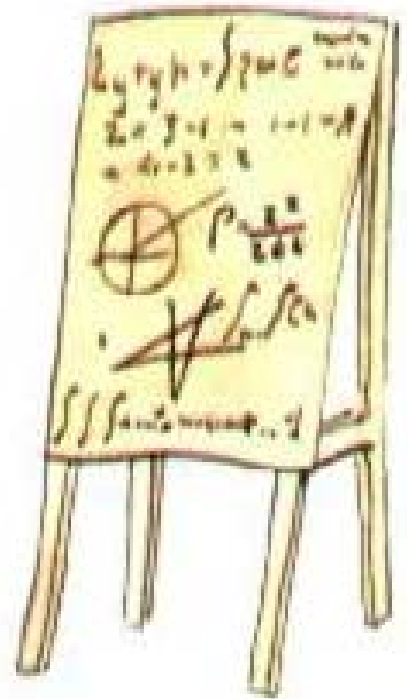
**Supported employment in DD:
Place then train**

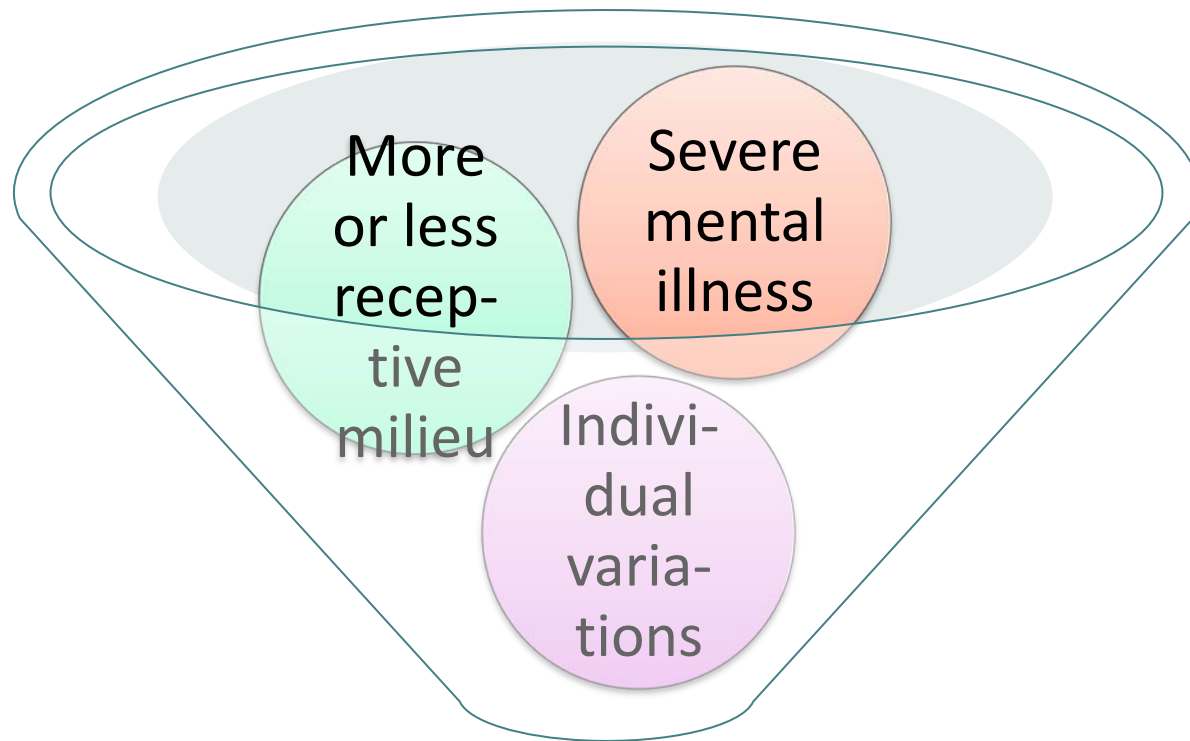


**Individual Placement and
Support (IPS) or Evidence-Based
Supported Employment**



Theoretical foundations





More or less favourable
course of illness



Some recover on their own:
Recovery possible

Various dimensions of recovery (Based on Whitley and Drake, 2010):

- *Clinical*

- *Symptoms*

- *Functional*

- *Community integration*

- *Physical*

- *Better health, healthy lifestyle*

- *Existential*

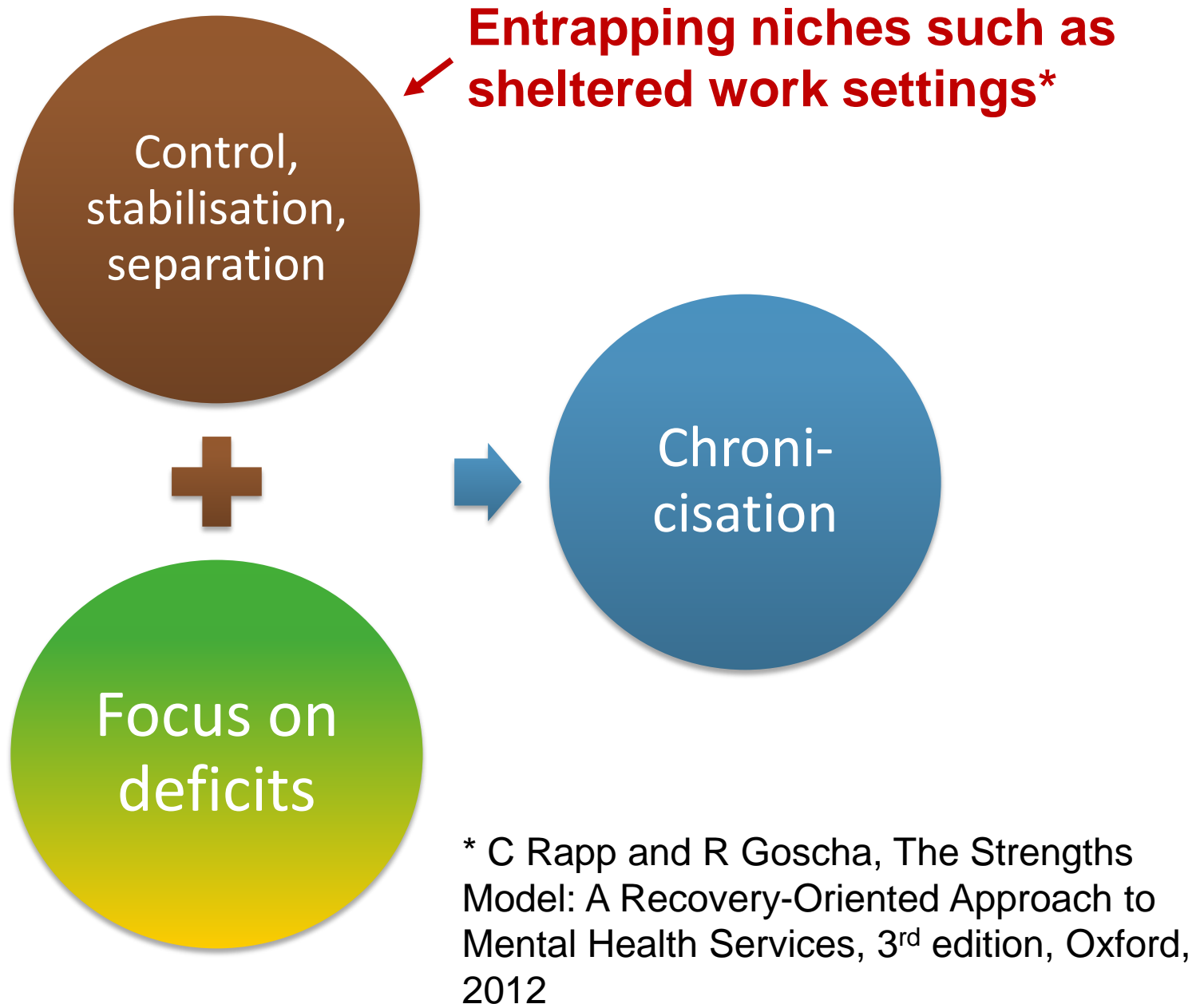
- *Empowerment, finding purpose to life*

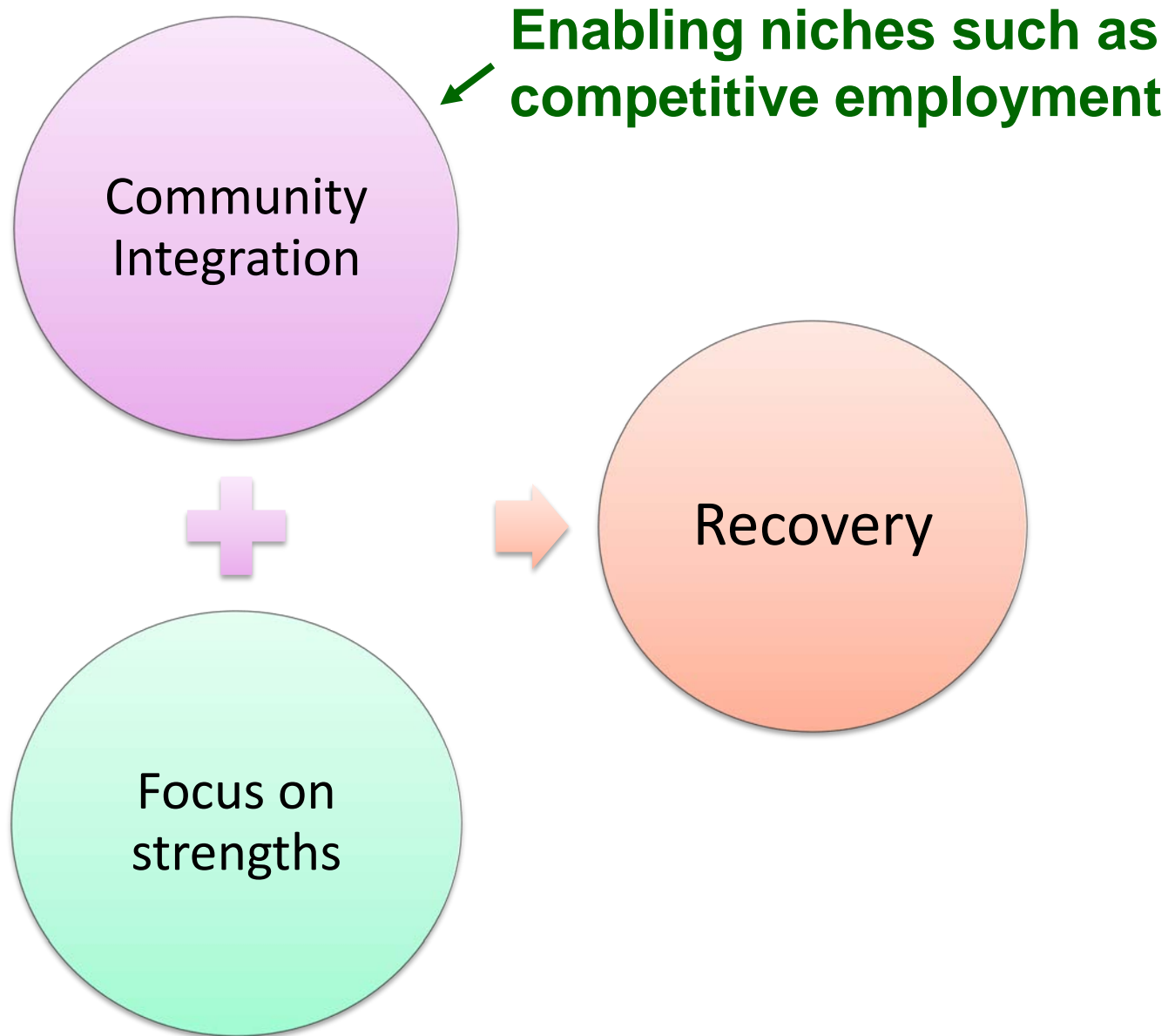
- *Social*

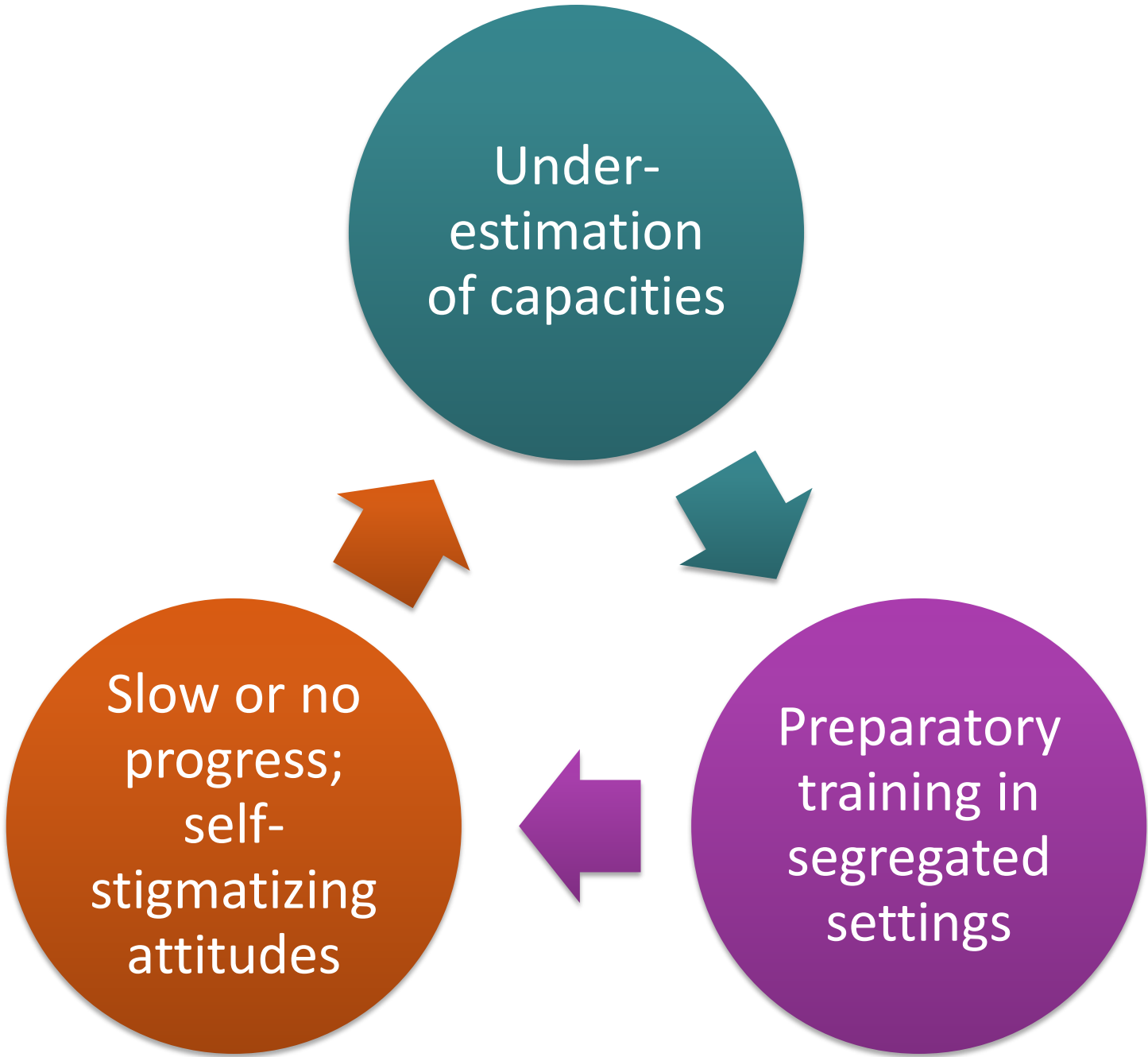
- *Having meaningful relationships*

Of these, work likely contributes to:

- ✓ *Clinical*
 - *Symptoms*
- ✓ *Functional*
 - *Community integration*
- ✓ *Physical*
 - *Better health, healthy lifestyle*
- ✓ *Existential*
 - *Empowerment, finding purpose to life*
- ✓ *Social*
 - *Having meaningful relationships*



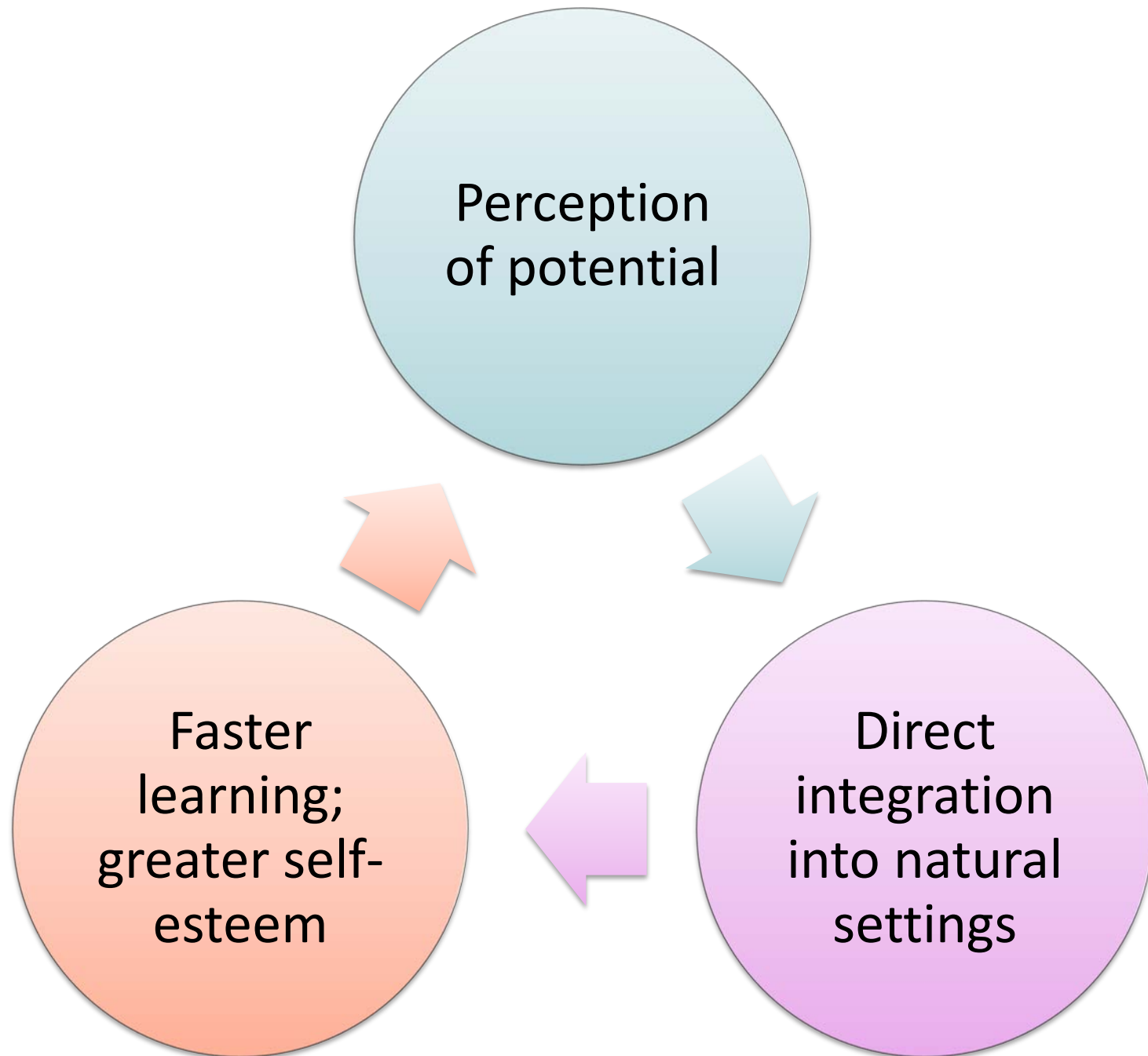




Under-
estimation
of capacities

Slow or no
progress;
self-
stigmatizing
attitudes

Preparatory
training in
segregated
settings



Principles

Target: competitive
employment



0%

Exclusion of participants who want to work

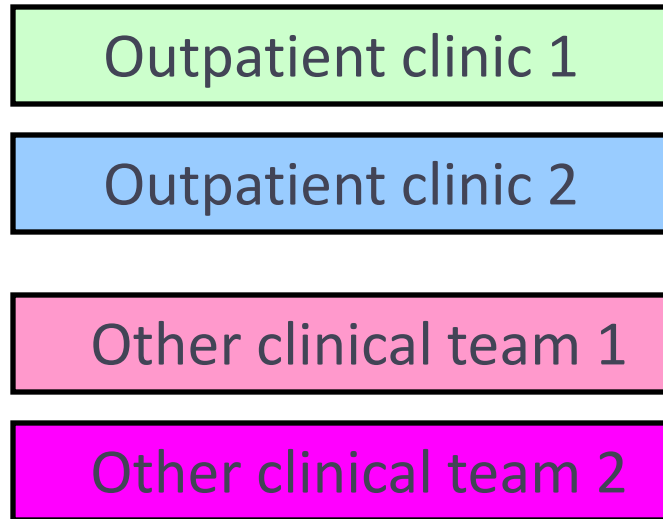
Focus on clients' work preferences



Rapid job search



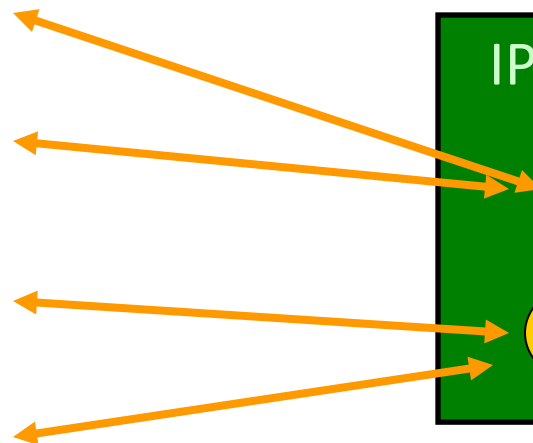
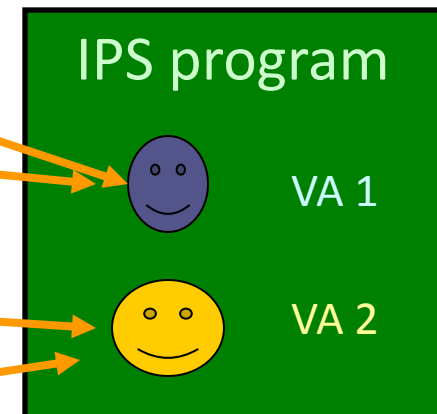
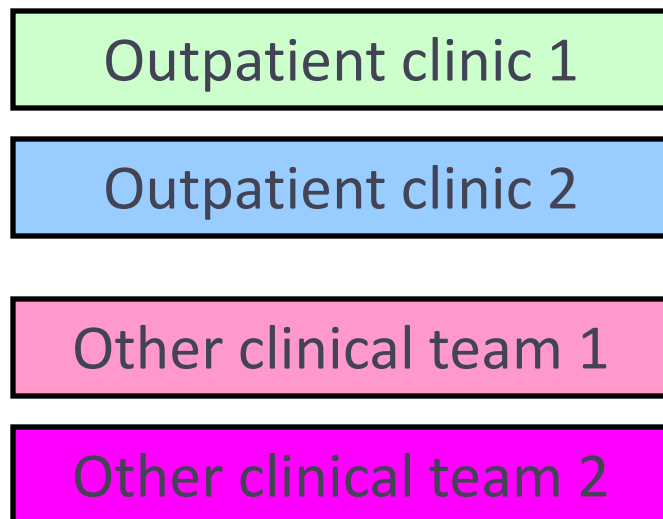
Typical situation



Little or no daily communication
between vocational and clinical
staff



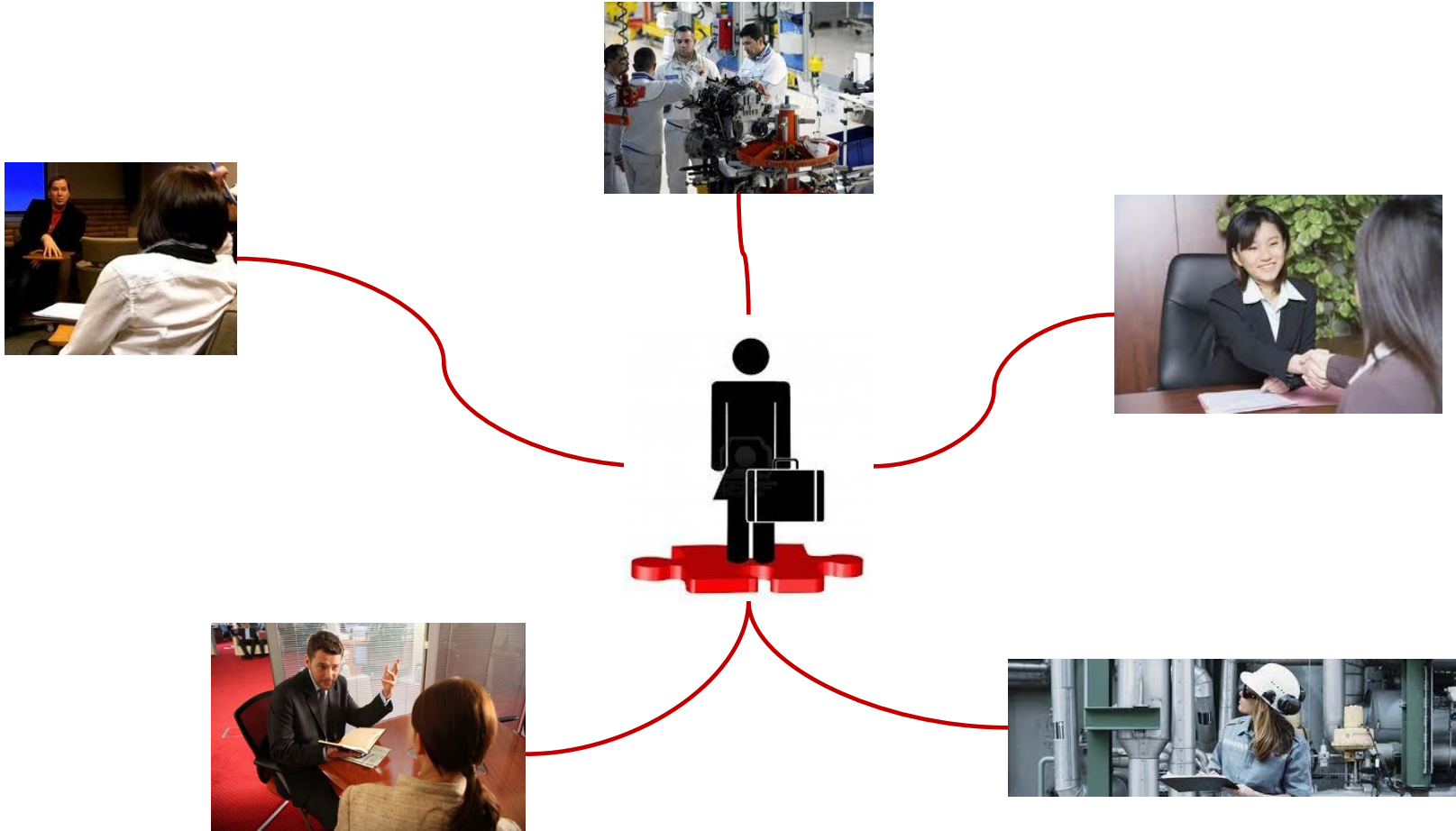
With IPS



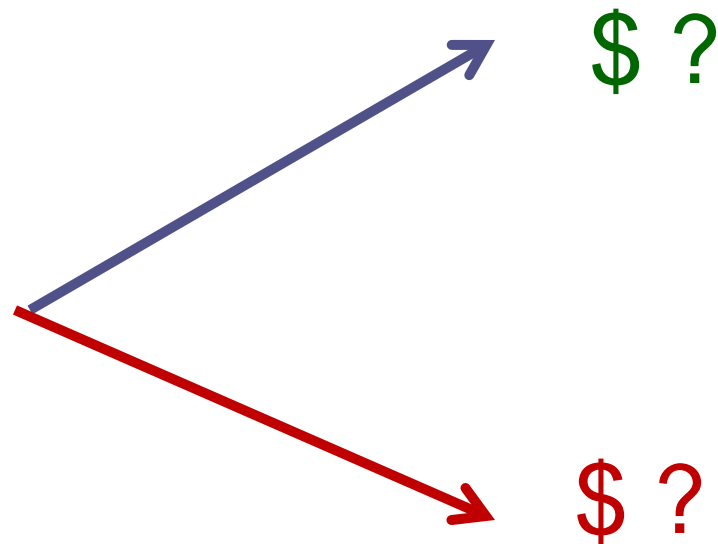
Individualized,
long-term
follow-along
services



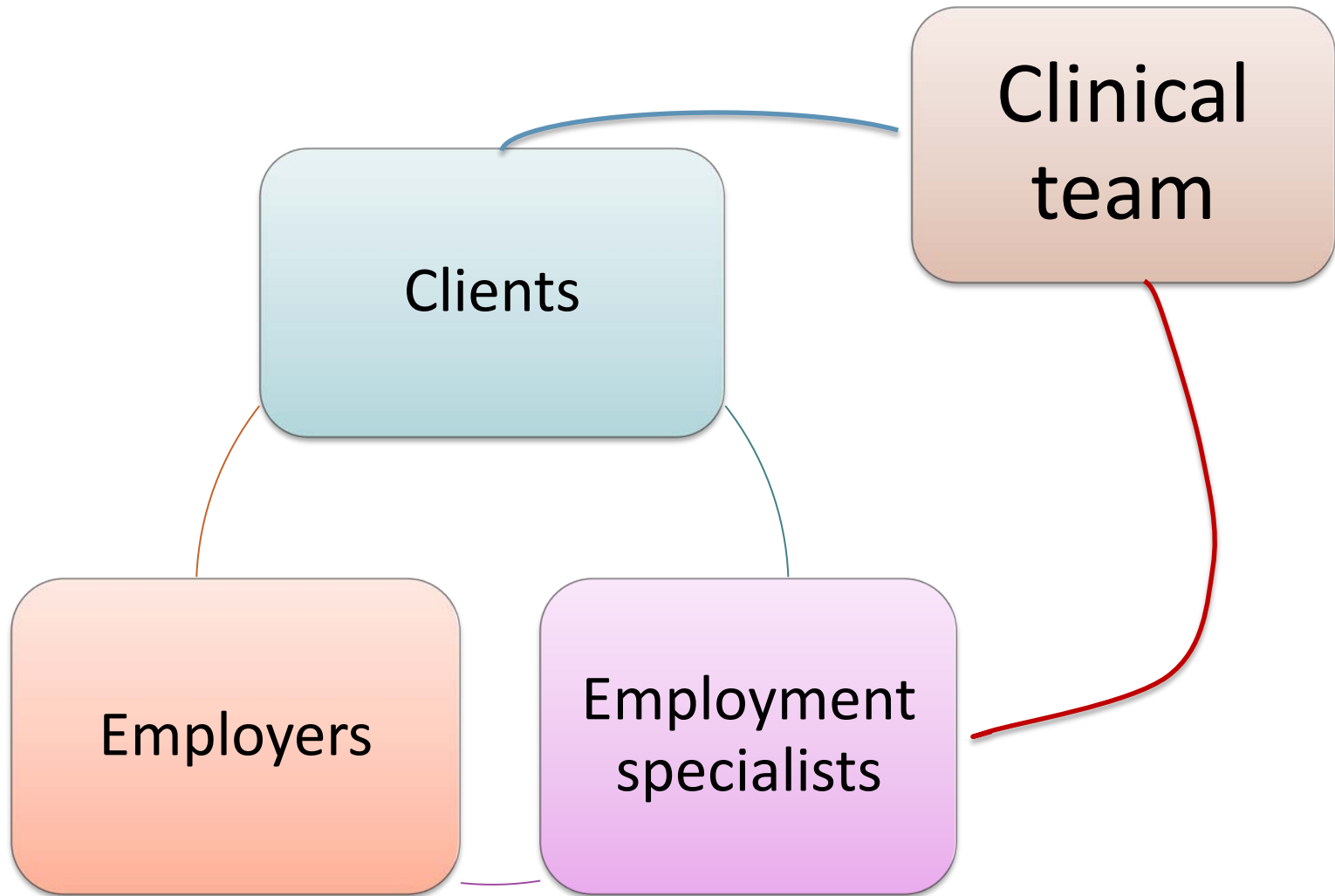
Systematic job development



Informations on consequences for benefits

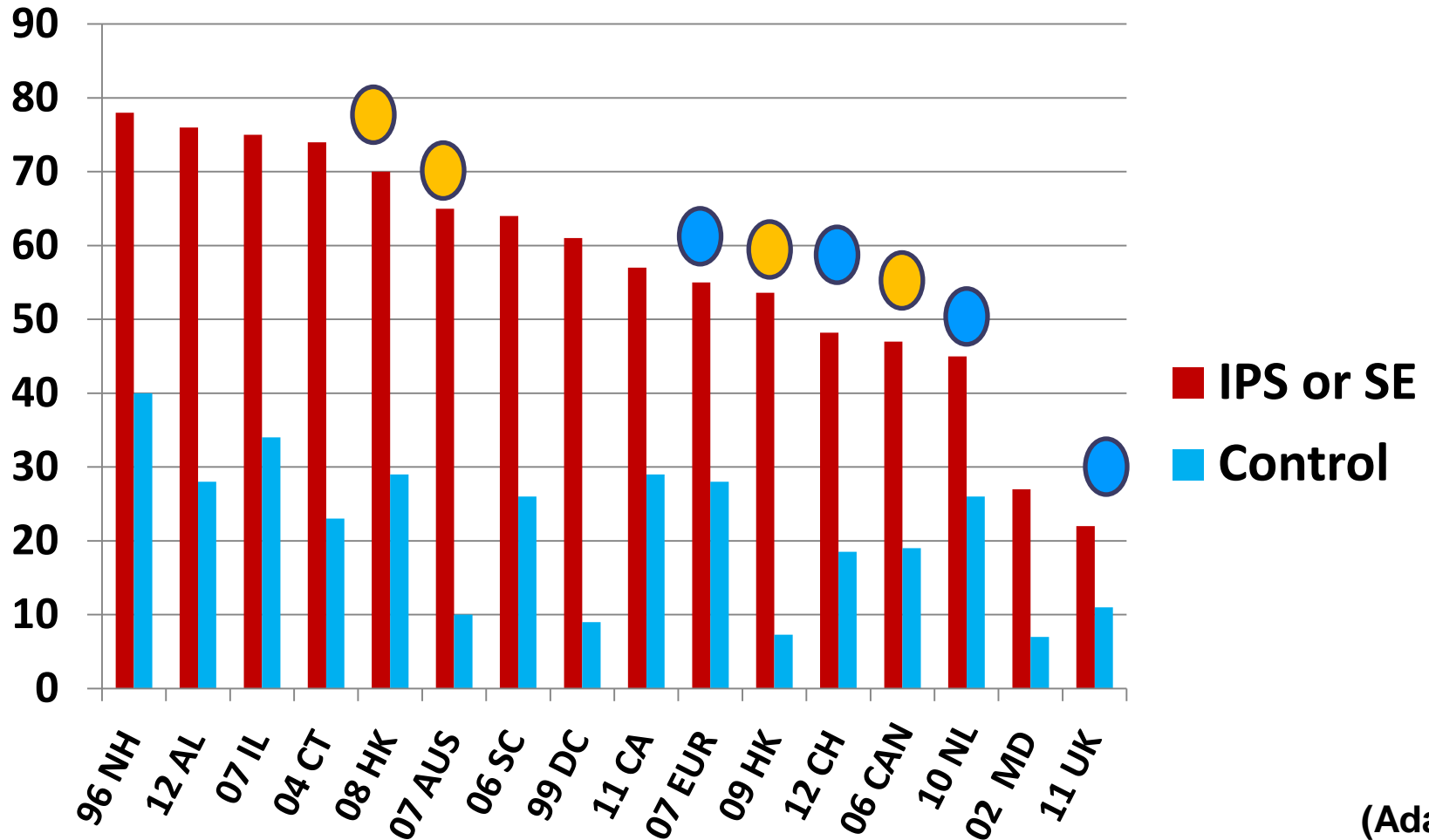


Links among types of people in IPS



Essential research results

Percentage of clients who obtained a competitive job, experimental studies, IPS



(Adapted
from Gary
Bond)

Generalizability outside U.S.

- Lower employment rates achieved in general: 47% (6 studies) vs 62% in U.S. (9 studies)
- But, except for Heslin et al. (2011) study in London, **always an important difference in favour of IPS**
- Noteworthy studies from a Canadian point of view: Latimer et al. 2006 (Montreal); Burns et al. 2007 (6 sites in Europe)

Job Duration

	IPS (N=307)	Controls (N=374)
Average weeks worked, all study participants	20,5	5,2
Average longest job, all study participants	17,4	4,6
Average weeks worked, workers only	29,2	21,5
Average longest job, workers	24,8	18,8*

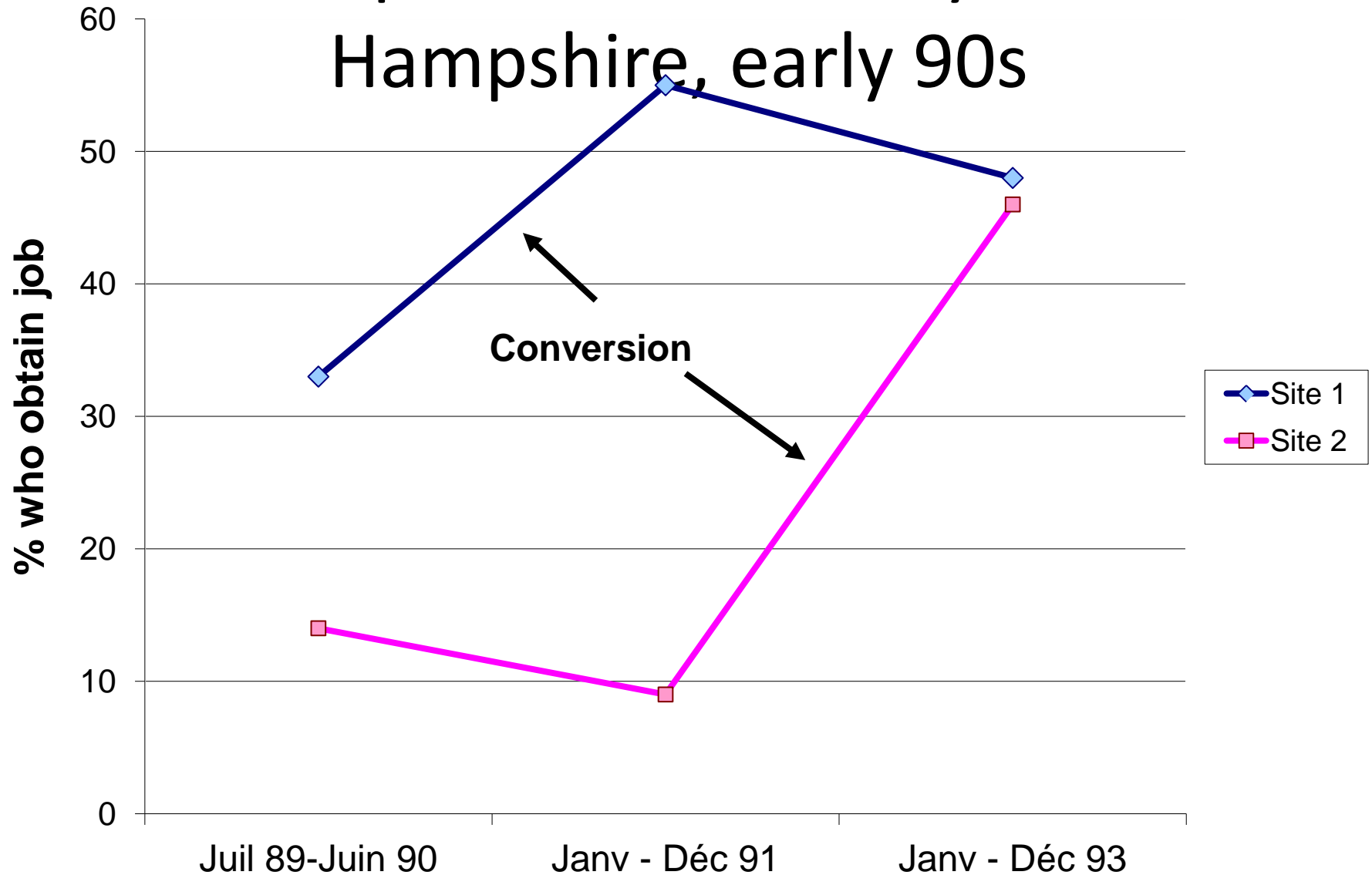
* All differences statistically significant except this one

Source: Bond et al., 2012

QUASI-EXPERIMENTAL STUDIES

- At least twelve studies use a quasi-experimental design with comparison group, before-after or retrospective, conducted in various countries including Canada (Vancouver), the U.K. and Sweden
- All conclude also that IPS is more effective than alternatives at increasing employment rates

Example: First IPS study, New Hampshire, early 90s



Measuring program fidelity

- Variable effects depending on how intervention delivered
- Old fidelity scale – 15 items such as:
 - Caseload (<25 = 5 ; >81 =1)
 - % time Employment specialists spend on case management (100%=5; <20% = 1)
 - Integration to clinical team (attached to clinical team, 3 or more contacts per week concerning a client= 5; no contacts = 1)
 - Etc.
- Total score:
 - 66 – 75: Good implementation
 - 56 – 65: Fair
 - < 56 : Not IPS
 - EQOLISE (European study): fidelity from 61 to 70 according to sites
- Note: New fidelity scale now available, 25 items; max. caseload now 20.

Greater fidelity ➡ Better outcomes

- At least 10 studies use 15-item scale
- 6 studies : statistically significant association; 2: trend; 1 n.s.; 1 not tested
- 1 study uses 25-item scale, results suggest similar predictive ability (Bond et al. 2012)

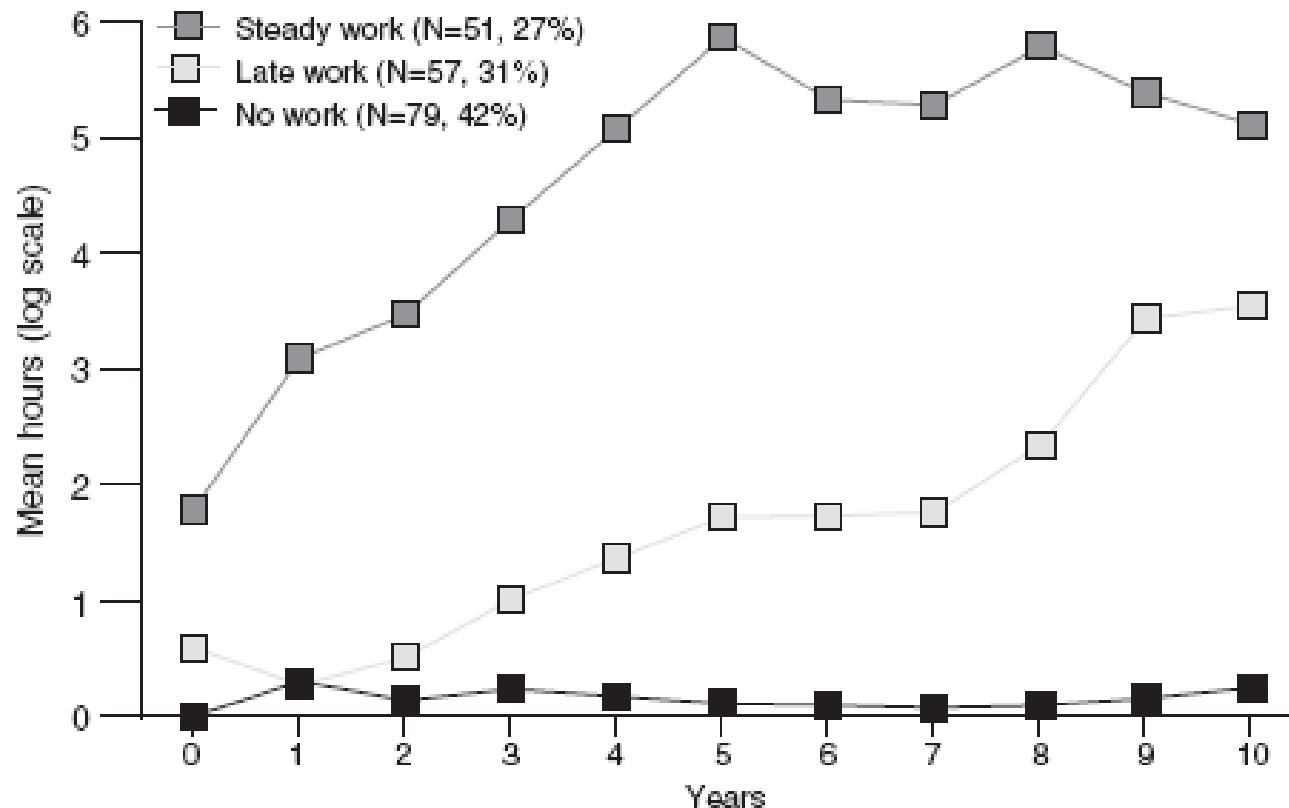
Long-term effects

- 2 long-term U.S. studies:
 - 10 years after (Salyers et al. 2004)
 - 8 to 12 years after (Becker et al. 2007)
- Between a third and two-thirds of participants who were contacted had worked half the time or more in a competitive setting over an 8 to 12 year period

10-year follow-up of clients with dual disorders in New Hampshire : Hours of work

Figure 1

Trajectories for working hours among 187 persons with a co-occurring substance use disorder and a long-term psychotic illness over ten years, by work group



Source: Bush
et al. 2009

Long-term effects of working – qualitative reports – NH dually- disordered clients

- For those who did work – *“the business and structure of work also tended to diminish the salience of symptoms”* (p. 264)
- *“Working or not working appeared to be reinforcing over time”* (p. 266)

(Strickler et al. 2009)

Effects on other domains

- Experimental and quasi-experimental studies:
 - Receiving IPS services is not enough in general (although Areberg et al. 2013 find difference between groups on quality of life, motivation, empowerment)
 - In some studies, working in a competitive setting has positive effects on:
 - Symptoms*
 - Self-esteem
 - Satisfaction with regard to personal finances
 - However Kukla (2012) reports no difference between competitive and non-competitive work, except that the latter is associated with greater social network.

* For those who worked, the “business and structure of work tended to diminish the salience of symptoms” - Strickler et al. 2009

Advantages of IPS, beyond effectiveness

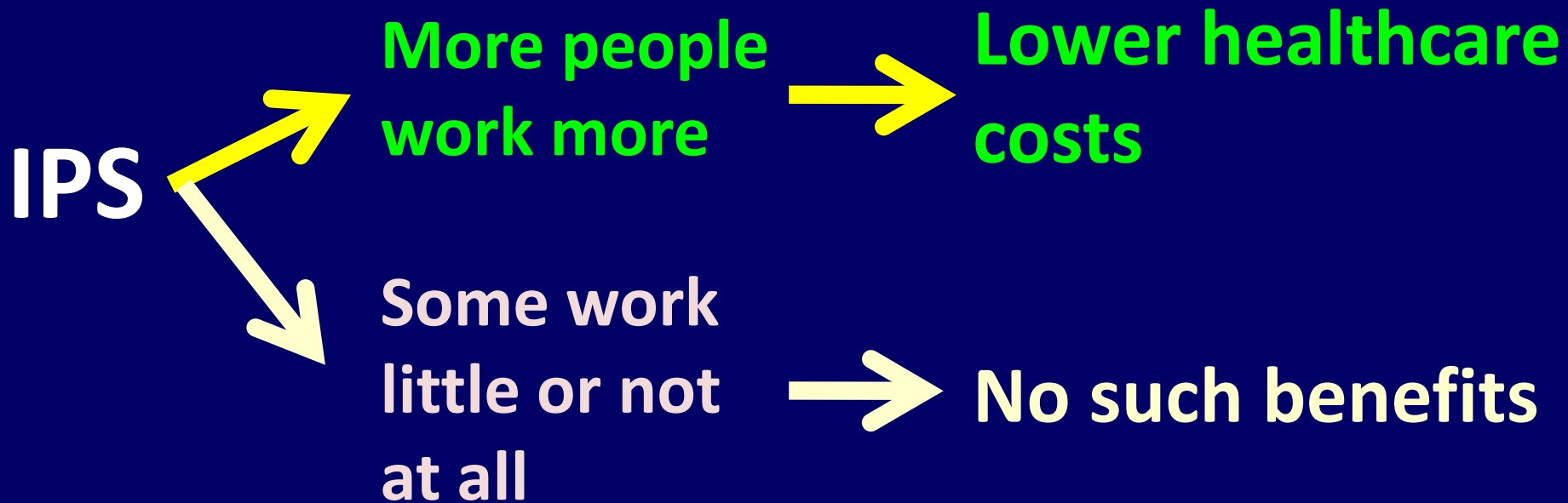
- Well-defined practice
- Adapts to client goals
- Consistent with societal objectives
- No negative side-effects
- Positive long-term benefits
- Reasonable costs
- Relatively easy to implement
- Adaptable

(Bond et al. 10)

Long-term effects on costs

- No indication of greater rate of relapse...on the contrary:
- Association between work and reduced mental health care costs (Perkins et al. 05; Bush et al. 09; Schneider et al. 09)
 - Bush et al: 166 350 \$ less over 10 years
- However, no conclusive proof that *IPS* causes a such a reduction
 - However some recent studies do point in this direction: Kilian et al. 12; Drake et al. 13.

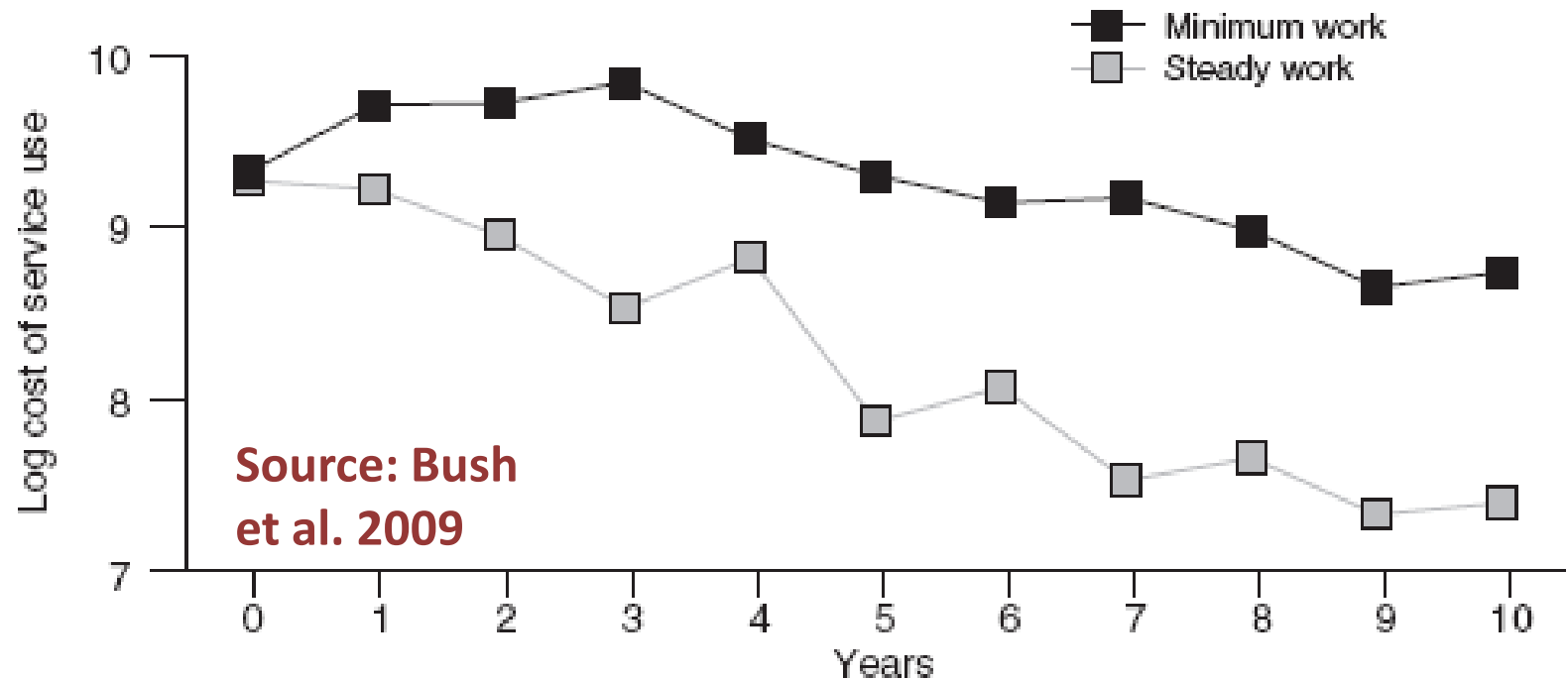
Being assigned to an IPS service per se
does not seem to reduce health care costs
at least in the short term, on average, but
working may do so



10-year follow-up of dually-disordered clients in NH: Cost trends by work involvement

Figure 2

Cost of outpatient services and institution days among 187 persons with a co-occurring substance use disorder and a long-term psychotic illness over ten years, by work group



Conclusions

- Competitive employment is a common goal of people who have not yet been socialized into the role of psychiatric patient
- IPS is an effective practice to reach that goal
 - Even in Europe, though employment rates tend to be lower there
- Higher fidelity is associated with better outcomes, so mechanisms are needed to promote higher fidelity
- Appears cost-effective (more efficient use of resources), especially in the long run