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## Special Feature Article

### Development and Implementation of IPS: A Long Winding Road

Teruo HAYASHI

Seiwakai Nishikawa Hospital

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#### Abstract

IPS (Individual Placement and Support) is a vocational service that is based on the place-train model developed in the United States since 1990s, in contrast to the train-place model (train=training, place=employment) that is mainstream in Japan. In the place-train model, pre-employment training is not required, and employment at a company in the community is aimed at an early stage, and individual support is provided after employment (i.e., supported employment). Until the end of the 1980s, support provided to people with severe mental disabilities in the United States was mainly sheltered workshops or institutional work. Subsequently, many social security systems were introduced to secure the employment of persons with disabilities, such as employment promotion for handicapped persons and tax incentives. Ironically, these approaches were however suggested to raise the risk of increasing the number of people dependent on security systems. Consequently, the supported employment model was recommended with the aim of gaining workers at companies in the community. At the same time, the theory of recovery and the strength model that emerged from social work spread, and IPS was established as a novel supported employment system for people with severe mental disabilities that incorporated the new concept of respecting the preferences and wishes of the person with disabilities. Therefore, what is emphasized in the relationship between users and supporters is shared decision making (SDM) rather than informed consent. IPS is gaining momentum internationally, and is being

institutionalized in developed countries. Although it has not yet been institutionalized in Japan, it shows a high competitive employment rate similar to those in Europe and the United States, such as about 2.5 times that of conventional employment support, and 50 to 60% of users are employed by companies, has been reported. It is hoped that IPS will continue to spread and expand in practice in Japan.

**Keywords:** Individual Placement and Support (IPS), implementation, employment promotion for handicapped persons, recovery theory, shared decision making (SDM)

### Introduction

Individual Placement and Support (IPS) is an employment support model based on the place-train model, which has been developed and practiced in the United States since the 1990s, in contrast to the train-place model (train = training, place = employment) that has been the fundamental form of employment support for people with mental disabilities in Japan.<sup>7)8)</sup> The traditional train-place model is an employment support approach based on the stress vulnerability hypothesis for people with severe mental disabilities. It involves step-by-step training through continued light work under supervision to enhance stress-tolerance before attempting actual employment.<sup>2)</sup> Consequently, it takes the form of group-based employment support, in which support-providers establish workplaces that people with severe mental disabilities attend. Support services provided in Japan's psychiatric

day-care programs, continuous employment support programs, and employment transition support programs generally follow this model. However, they often do not lead to achieving the ultimate goal of competitive employment or regard it as a substantive goal.<sup>3)</sup>

The place-train model aims for early employment in general companies, treating the actual workplace experience itself as training and providing individualized support that continues after employment.<sup>3)</sup> In this case, step-by-step pre-employment training is not required; priority is given to securing employment in a workplace matching the individual's preferences and characteristics. Within supported employment, IPS was developed as an evidence-based employment support program specifically for people with severe mental disabilities. The support conditions and outcomes of IPS have been carefully validated through

clinical research, and the current IPS program is recommended to be implemented based on eight core principles (Refer to Figure 1). Key features of IPS include: providing individualized support for anyone seeking employment without exclusion criteria; initiating job search activities early without pre-employment training; prioritizing the individual's preferences and strengths while developing matching workplaces within the community; and providing ongoing support not only to the individual but also to the employer after placement.

IPS was developed in the United States and initially spread within that country; subsequently, it became adopted by institutions in several developed nations.<sup>3)7)8)</sup> While not yet nationally adopted by institutions in Japan, it is already practiced in over 20 medical institutions and welfare service providers.<sup>9)</sup> Japan has also confirmed high competitive employment rates comparable to those in Europe and the US (approximately 2.5 times higher than with conventional employment support, with employment rates of 50-60%), and differences in effectiveness between countries are not marked.<sup>4)9)</sup>

In today's global society, the sharing of information and values has accelerated, and this has had a marked impact on healthcare and welfare. While differences exist in national

systems and character, within the mental health field, concepts such as recovery theory and person-centered approach for persons with disabilities are being increasingly recognized as shared values. This paper primarily aims to introduce the history of IPS. However, it seeks not merely to provide knowledge about IPS, but also, by tracing its history, to help those involved in mental health and welfare understand the movement of values, and serve as an opportunity to consider the appropriate future direction of mental health and welfare practice in Japan.

## **I. Early Employment Support for Persons with Mental Disabilities in the United States**

### **1. Sheltered Employment**

Employment support for persons with disabilities in the United States is reported to have begun in the early 1900s, targeting demobilized veterans. The Social Security Act of 1935 extended eligibility to the general public, and the Barden-LaFollette Act adopted in 1943 recognized persons with mental disabilities as eligible for employment support. However, the impact of this legislation became more apparent after the 1950s, when many persons with mental disabilities transitioned to community living due to the deinstitutionalization movement. Until

the late 1980s, the primary support provided for individuals with mental disabilities was sheltered employment, primarily facility-based, in settings known as sheltered workshops, institutional work, and work enclaves (workstations within companies). Subsequently, work within day-care centers was also introduced.<sup>3)4)</sup>

## 2. Employment Support as Psychosocial Rehabilitation

Starting in the 1980s, community mental health centers were established across the United States, providing psychosocial rehabilitation primarily through these centers. Among these, Fountain House in New York State introduced a transitional employment program,<sup>1)</sup> initiating a pioneering approach in which individuals undertook short-term part-time work in general businesses as part of psychosocial rehabilitation. This activity spread to other mental health centers, promoting a trend in which similar initiatives were adopted. By the 1990s, several employment support models had been proposed and put into practice. These included approaches emphasizing skills training and work aptitude assessment, approaches focusing solely on job search activities, and employment support delivered within comprehensive community-based treatment programs (Assertive

Community Treatment: ACT). However, clinical research failed to demonstrate the effectiveness of any of these approaches in securing general employment.<sup>2)13)</sup>

## II. Factors Influencing the Structural Formation of IPS

In the 1990s, supported employment, including IPS, entered its early stages. Multiple factors facilitated the introduction of supported employment, including institutional challenges, advances in mental health models, the development of community mental health approaches, progress in effectiveness research in mental health, treatment advancements, and multifaceted dissemination activities. As one example, the table summarizes the evolution of mental health services in Vermont, where IPS was first introduced, along with the process leading to its adoption. It shows that the spread of IPS was influenced by changes in multiple factors, including the content of treatment and support, support environment, perspective of service users, and provider–service user relationship. Below, we introduce factors that influenced the introduction of IPS, while deferring discussion of the progress of effectiveness research in the mental health field to another article in this special feature category.

## 1. Institutional Issues

While individuals with mental disabilities were included as beneficiaries of employment support under the Social Security Act and Barden-LaFollette Act, it was the Rehabilitation Act of 1973 that provided the impetus for delivering more coordinated and effective support to persons with disabilities. This law mandated the establishment of Vocational Rehabilitation Offices in each state to promote, implement, and oversee employment support for persons with disabilities, including mental disabilities. This led to the introduction of numerous systems guaranteeing employment for persons with disabilities, such as disability employment programs, temporary wage subsidies, and tax incentives. Ironically, however, these public support measures were not always effective in fully achieving their original goal of increasing the number of general workers (i.e., taxpayers). Instead, concerns were raised that they risked increasing the number of people dependent on such support. Consequently, the Rehabilitation Act was amended in 1986. This amendment included provisions promoting supported employment, which guarantees employment in general businesses and workplace retention support, thereby promoting the

implementation of supported employment.<sup>14)16)</sup>

## 2. Advancements in the Mental Health Model

As mentioned earlier, in the employment support that originated from psychosocial rehabilitation, issues such as excessive emphasis on pre-employment assessment were pointed out; however, this served as an opportunity to introduce the new concept of respecting the preferences and wishes of persons with disabilities in employment support.<sup>5)</sup> Furthermore, the recovery theory and strength model,<sup>15)</sup> which originated from social work, brought about a change in the conventional medical perspective that had focused on the pathologies and functional impairments of people with mental disabilities, promoting the idea of utilizing their healthy aspects and abilities. This brought about a major paradigm shift in employment promotion for persons with disabilities, ultimately accelerating the diversification of employment support approaches. IPS, in particular, incorporates this theory at its structural core. The current model positions prioritizing the user's preferences and strengths in workplace selection and employment retention as the most critical element of support. At the same time, recent changes in the relationship

between individuals (patients) and support providers (therapists) have markedly influenced employment support, particularly the development of IPS. Transitioning from the paternalism in which treatment policies were unilaterally determined by traditional practitioners, through the stage of informed consent in which services were provided based on thorough explanation and with the individual's consent, shared decision-making (SDM) has been introduced into psychiatric rehabilitation, including employment support.<sup>3)18)</sup> Emphasizing SDM and matching occupational choices to the individual's values and preferences has been noted as potentially increasing job satisfaction and employment retention rates.<sup>10)</sup> The spread of these new concepts bolstered the rights advocacy movement and exerted significant influence. The National Alliance on Mental Illness (NAMI), with state chapters across the United States, also supported the implementation of IPS as part of its efforts to restore the rights of people with mental disabilities and promote the reduction of stigma.<sup>6)</sup>

### 3. Advances in Community Mental Health Approaches

ACT significantly contributed to the spread of a model in which multidisciplinary teams support people

with mental disabilities in the community.<sup>19)</sup> This form of multidisciplinary treatment remains widely accepted today as the fundamental model for community-based care. However, ACT tends to specialize in life support services, and its effectiveness in employment promotion for persons with disabilities has not been consistently replicated. Furthermore, in the United States, it often involved complicated referral procedures, in which other therapists or supporters had to refer clients to independent ACT teams. Consequently, a trend of actively referring employment support cases to ACT teams did not emerge.<sup>12)</sup> Conversely, a multifunctional and comprehensive support model became mainstream, in which multidisciplinary treatment teams were organized within mental health centers or medical institutions. Operating under a 24-hour support system, it covers the acute emergency response, daily living and housing support, family psychoeducation, treatment including comorbid disorders (such as substance abuse), peer support, and IPS employment support.<sup>12)17)</sup> The Howard Center, a mental health center in Vermont observed by the author, also operated multiple multidisciplinary support teams consisting of team supervisors, psychiatrists, psychiatric nurses, case managers, home support

workers, peer supporters, and IPS employment support specialists. Through regular conferences to share information, they conducted a community rehabilitation and treatment program covering overall community support.<sup>17)</sup> The table shows the transitions in treatment and support models and their delivery settings in Vermont, reflecting the emergence and implementation of new mental health concepts.

#### 4. Advances in Treatment

Advances in pharmacotherapy for schizophrenia, in particular, significantly impacted employment support. Antipsychotic medications can cause sedation, extrapyramidal side effects, and cognitive dysfunction, which often hindered employment. The development and widespread use of second-generation antipsychotics, along with the introduction of their long-acting injectable formulations, proved especially beneficial for employment support services like IPS, which aim to facilitate employment in general companies. Furthermore, the aforementioned SDM approach emphasizes respecting the preferences and values of persons with disabilities regarding medication and drug selection. For those seeking employment or already employed, this fosters a sense of self-determination in

choosing and taking their medication, leading to expectations of improved medication compliance.<sup>20)</sup>

### III. The Spread of IPS

In the development, research, and implementation of IPS, the group led by Drake, R.E., Becker, D.R., and Bond, G.R. played a pioneering and crucial role. Facing the aforementioned institutional challenges and demand for transformation of the mental health model, Drake, a psychiatrist researching community psychiatry at the Dartmouth Psychiatric Research Institute, began developing supported employment for people with severe mental disabilities.<sup>3)</sup> First, he requested cooperation from Becker, then director of a psychiatric day care center in New Hampshire, for a pilot project, through which they developed the prototype of the current IPS in 1989. The author had the opportunity to hear directly from these three individuals (including the researcher Bond), about that time. Their accounts revealed that while IPS proved groundbreaking from the outset, its path to implementation was far from smooth. Flint, L., at the Vermont Department of Mental Health provided an interesting slide summarizing the feedback they received from others when they first prototyped and began implementing IPS, which is presented as Figure 2. With IPS-style support,

approximately half of Becker's daycare users secured employment in general businesses, including part-time work, within three years. Recognizing this effect, and at the request of persons with disabilities and their supporters, similar initiatives were introduced in some other daycare centers.<sup>3)</sup> Conversely, many support providers were skeptical of this outcome, voicing objections, such as: "there is no precedent" and "it involves risks." However, the evidence-based scientific approach emphasized by Drake, Becker, Bond, and others proved persuasive. Gradually, understanding grew among practitioners, administrators, and family support groups, leading to widespread acceptance of IPS from the 2000s onward.<sup>7)</sup> Furthermore, practitioners of IPS took the lead in establishing the IPS Learning Community conference, held annually since 2002 as a forum for learning and exchanging ideas. Starting in 2017, it became international, allowing participation from practitioners, administrators, persons with disabilities, and researchers outside the United States.<sup>7)</sup> The homepage of the IPS Employment Center they launched<sup>11)</sup> widely shares information, learning materials, and research data on IPS, designed to be accessible to anyone.

## Conclusion

This paper discussed the background of IPS development and implementation, along with factors that influenced it. The initial process of introducing IPS involved sharing the challenges of the train-place model among persons with disabilities, their families, researchers, and government officials. What proved effective here was persuasion based on evidence, a rare case in the field of psychiatric rehabilitation. However, this was not the only reason the place-train model gained attention. Attention and agreement were gained based on the fundamental logic that a single model could only cover part of the needs of persons with disabilities, and that employment support required a model offering multiple choices.

Furthermore, the rise of concepts such as recovery and the strength model, which broadly influenced mental health care, served as a major driving force behind the creation of IPS. The underlying philosophy of these models: placing the individual's preferences and strengths at the center to reconstruct life goals, not only complements employment support well but also enhances the effectiveness of general employment support itself. As treatment advances, more people with mental disabilities now live in their communities compared with the past. Concurrently, a multi-professional

mental health and welfare support system has been established. In this context, competitive employment support has become indispensable for achieving true community integration and reducing stigma. This is an indisputable fact, not only in Western countries but also in Japan. Within this trend, it may become inevitable that support approaches like IPS will be sought and implemented widely.

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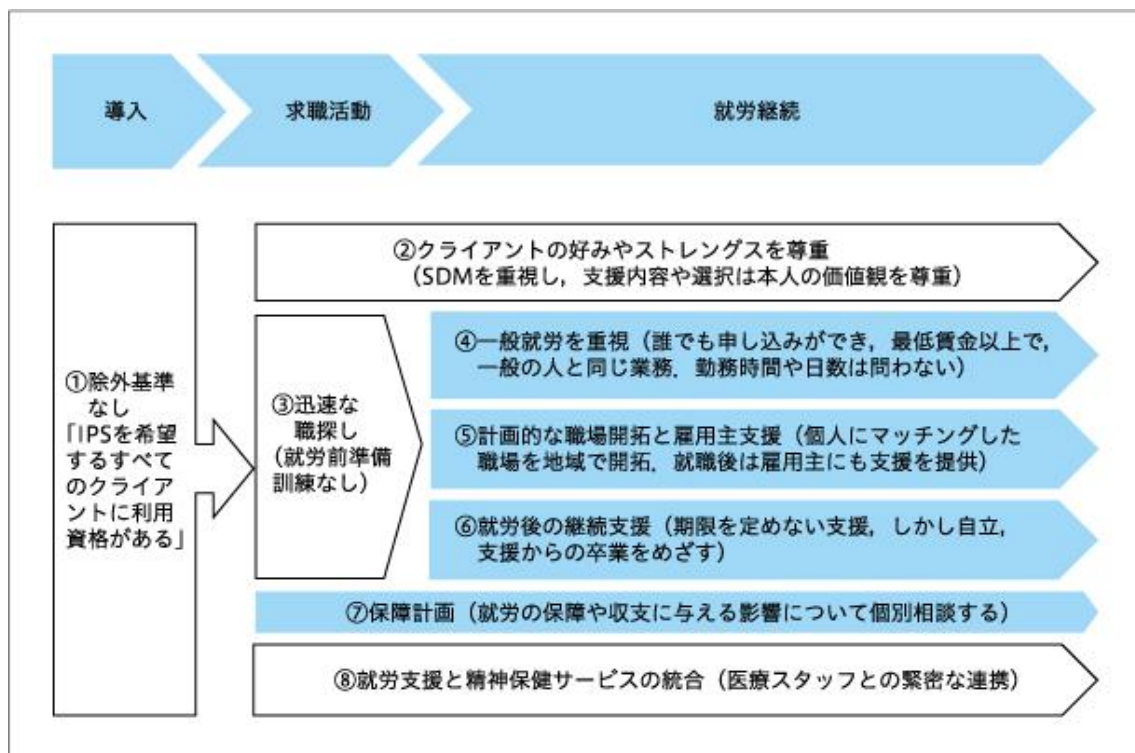


図1 IPSの8原則

Figure 1: The 8 Principles of IPS

表 米国の精神保健の変遷（ベルモント州の例）

	1950年代	1960~1970年代	1980年代	1990年代	2000年代	2010年以降
治療・支援内容	精神科病院への収容	雇用なし、保護的労働（院内作業）	過渡的雇用（短期、一過性）、作業訓練、就労移行	就労支援、障害者雇用	IPS、一般雇用の実現	IPS、リカバリーのための一般就労
支援環境	隔離	分離	保護的	一部地域	地域主体	地域、職場
治療・支援を受ける人の立場	患者	患者	利用者	利用者	クライアント（受給者）	個人、求職者
施策に影響したモデル	医学	医学、管理、保護	コミュニティ	生活	リカバリー	パーソン・センタード・ケア、リカバリー、協働ケア
治療・支援の特徴	隔離、隔絶	危険回避、保護	危険回避と保護、人権擁護運動の勃興	人権擁護、インフォームド・チョイス	共同意思決定（SDM）	ピアサポート、ナチュラルサポート

IPS 導入には、支援環境や支援モデル、治療・支援関係の変化など複数の要因の変化が影響している。本邦でも同様な変遷をたどっているが、現状は米国の1980~1990年代に近いと考えられる。2010年以降は、IPSの一般就労支援はあくまでも手段であり、本質的な目的はリカバリー実現という考えに至っている。また、近年では、支援者のみが支援するという立場を離れ、職場の同僚や家族を含めた周囲の市民が交流のなかで結果的に支援するというナチュラルサポートという概念が定着しつつある。

Table: Evolution of Mental Health Care in the US (Example: Vermont)

1950s / 1960s–1970s/ 1980s / 1990s / 2000s / 2010s Onward

#### Treatment/Support content

Institutionalization in psychiatric hospitals

No employment, sheltered work (in-hospital labor)

Transitional employment (short-term/temporary), job training, employment transition

Employment support, employment for people with disabilities

IPS, achieving mainstream employment

IPS, mainstream employment for recovery

#### Support environment

Isolation

Separation

Sheltered

Partially community-based

Community-led

Community, Workplace

#### Position of the person receiving treatment/Support

Patient

Patient

User

User

Client (Recipient)

Individual, Job seeker

Model influencing policy

Medical

Medical, Management, Protection

Community

Living

Recovery

Person-centered care, Recovery, Collaborative care

Characteristics of treatment/Support

Isolation, Segregation

Risk avoidance, Protection

Risk avoidance and protection, Emergence of human rights advocacy

Human rights advocacy, Informed choice

Shared Decision Making (SDM)

Peer support, Natural support

The introduction of IPS has been influenced by changes in multiple factors, including the support environment, support models, and treatment/support relationship. Japan has followed a similar trajectory, although its current stage is considered closer to that of the United States in the 1980s and 1990s. Since 2010, the understanding has evolved that IPS-based competitive employment support is merely a means to an end, with the fundamental goal being the realization of recovery. Furthermore, in recent years, the concept of “natural support” has been gaining traction. This shifts away from the position where only support professionals provide assistance, instead involving surrounding citizens, including workplace colleagues and family members, who provide support incidentally through their interactions.

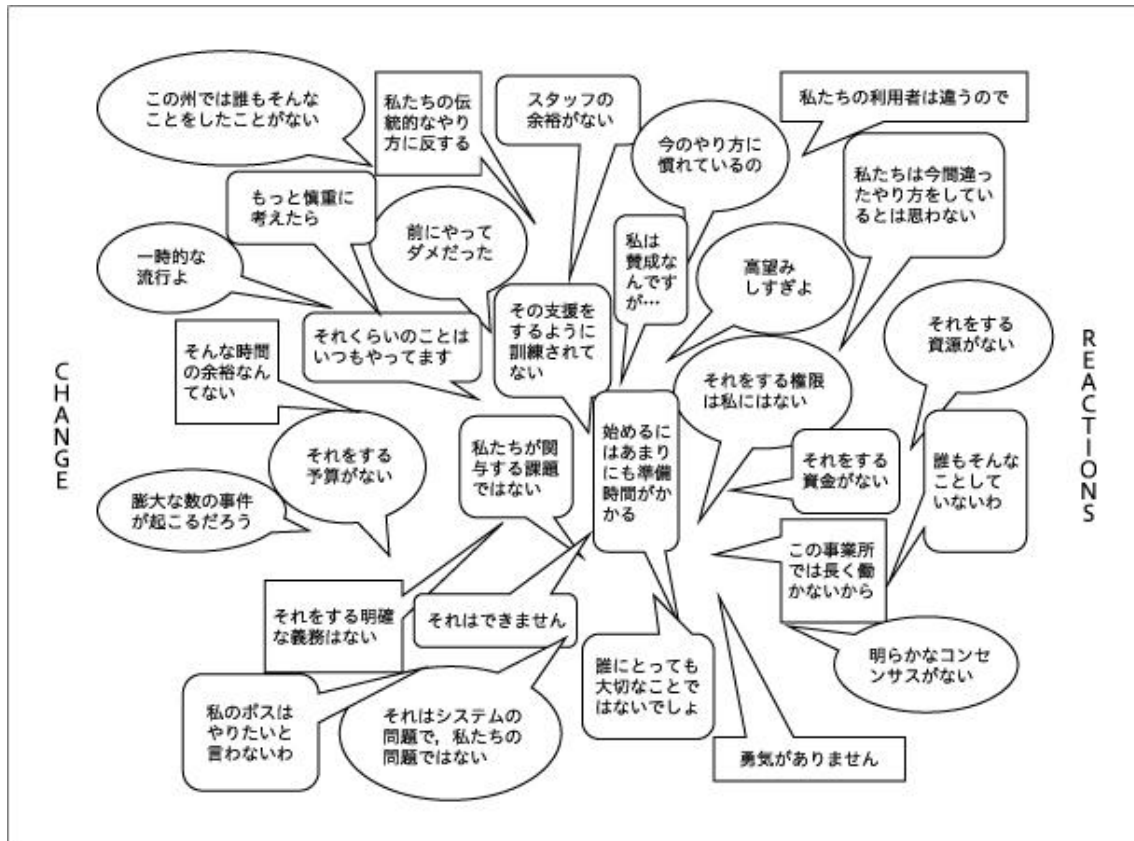


図2 IPS導入当初の周囲の声

IPSがニューハンプシャー州、ベルモント州などで導入し始められた頃、周囲からは懐疑的な声が多く聞かれた。しかし、支援効果の科学的検証データや良好なアウトカムが認知されるにつれて、周囲の反応は変化していった。その当時の実践者、家族、当事者から聞かれた声をまとめたスライド。  
(ベルモント州精神保健局 Flint, L.から供与されたものを日本語訳した)

Figure 2: Initial Reactions to IPS Introduction

When IPS began to be introduced in United States such as New Hampshire and Vermont, many skeptical voices could be heard. However, as scientific validation data on the effectiveness of support and positive outcomes became recognized, the surrounding reactions gradually changed. The slides summarize comments made by practitioners, families, and persons with disabilities at that time.

(Translated from information provided by Flint, L. of the Vermont Department of Mental Health)