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Special Feature Article

Necessity and Issues of Institutionalization of Individual Placement and Support in Japan

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Abstract

IPS (Individual Placement and Support) is an evidence-based practice which has eight principles to be observed, and Japanese version of the fidelity scale developed for domestic application has shown convergent validity with employment rates. Although IPS should be technically feasible in Japanese institutions with appropriate staffing and expected to deliver good employment outcomes, it has been implemented in only a small number of institutions as work transition support projects at welfare offices or as part of psychosocial rehabilitation at medical facilities. This paper describes the experience in practicing IPS in psychiatric day care at the National Center Hospital, National Center of Neurology and Psychiatry (NCNP) and outlines the current domestic situation where it is difficult to secure sufficient revenue for the continuous practice of IPS either as a medical service or as a welfare service. Issues in institutionalization, which is deemed necessary to accelerate the social implementation of IPS in Japan, are also discussed.

Keywords: Individual Placement and Support, employment transition support, psychiatric day care, medical fee system, recovery support

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Introduction

IPS (Individual Placement and Support)[1)5)] is an evidence-based practice (EBP) developed and validated in the United States primarily as employment support for people with severe mental illness, and its effectiveness has also been confirmed in Japan.[2)4)6)7)9)12)14)]

When implementing IPS, it is crucial to understand and adhere to its eight principles (detailed explanation is provided elsewhere). Furthermore, the fidelity scale can serve as a more concrete guideline. The Individual Placement and Support Fidelity-25 items version (IPS-25),[3)] published by Bond, G.R. et al. in 2012, consists of 25 items that evaluate whether practice adheres to the eight principles, and includes three subscales: staffing, organization, and services. A Japanese translation is also publicly available. Based on IPS-25, a Japanese version of Individual Placement and Support Fidelity Scale[13)16)] was also developed for application in Japan. These scales have demonstrated convergent validity with employment rates, and reading them allows one to understand what kind of organization to establish and how to provide services to implement good IPS practice.

Thus, from both an academic perspective and the standpoint of technical feasibility, the conditions for IPS dissemination in Japan are gradually being established. However, as of November 2022, only 20 facilities nationwide were publicly listed as IPS-implementing facilities on the Japan Individual Placement and Support Association (JIPSA) website (although the actual number of registered facilities is slightly higher). Of these, 15 facilities provide IPS as part of their work transition support projects, while the remaining 5 are medical facilities. Among these medical facilities, 3 are considered to practice IPS within psychiatric day care programs or in collaboration with such programs. Psychiatric day care programs, by their facility standards, are based on providing psychosocial rehabilitation through a multidisciplinary team. They target individuals with severe mental disorders, including schizophrenia, and offer support integrated with medical care, creating an environment conducive to considering the implementation of IPS. However, in reality, continuous implementation of the IPS model within psychiatric day care centers presents challenges. As the attending physician in charge of National Center Hospital, National Center of Neurology and Psychiatry (NCNP) Psychiatric Day Care (hereafter NCNP Day Care), the author

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was involved in introducing the IPS model. Unfortunately, after eight years of practice, new IPS support activities were discontinued. This paper examines the necessity and challenges of IPS institutionalization, drawing on experience at NCNP Day Care.

I. Introduction of IPS at NCNP Day Care and Its Outcomes

1. Background Leading to Introduction

One distinctive feature of NCNP Hospital is the establishment of specialized disease centers. In addition to the hospital, NCNP houses two research facilities (National Institute of Mental Health and National Institute of Neuroscience). This structure enables cross-departmental collaboration among clinicians and researchers focused on specific disease groups, facilitating the provision of highly specialized team-based care and development of new diagnostic methods and treatments. One such initiative was the establishment in 2010 of Community Psychiatry Model Practice Center (now Community Psychiatry and Recovery Support Center). Its purpose was to reorganize the functions of existing departments, including acute care wards, community support offices, home-visit nursing, psychiatric day care, and occupational therapy rooms, to provide team-based care primarily for patients with severe mental disorders and establish a model of comprehensive community-based psychiatric medical care in the hospital's surrounding area. The core activities centered on three departments: Social Rehabilitation Research Department (now Department of Community Mental Health and Law) of National Institute of Mental Health, Psychiatric Day Care Center, and Home-visit Nursing Station. An advanced clinical activity assigned to Day Care Center was employment support within the context of recovery support, specifically introduction of the IPS model. This was also a requirement for participation in the multi-facility collaborative research project initiated in fiscal year 2010, funded by the Ministry of Health, Labour and Welfare Scientific Research Grant [Practical Application Research Project for Medical Care in the Field of Intractable Diseases, Cancer, etc. (Mental Disorders Research Field)]: "Research on Creating a Community Psychiatric Care Model that Promotes 'Community Life-Centered' Care and Verifying its Effects."[10]

2. Renovation of NCNP Day Care

NCNP Day Care was previously a long-stay type of day care. To transform it into day care capable of implementing IPS, changes were carried out. The most significant challenge was strengthening manpower in terms of both quantity and

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quality. Implementing IPS necessitates appointing employment specialists (ES). Additionally, to support employment assistance, we needed to enhance daily living support services and reinforce case management staff to ensure the day care program could operate even when staff were engaged in outreach. Therefore, using research funds, we expanded personnel, conducted training on recovery support and IPS, and worked to unify support philosophies and improve support techniques among staff. Furthermore, to strengthen collaboration between employment support and medical care, the day care physician was clearly positioned as a team psychiatrist, and when necessary, the team psychiatrist would also serve as the primary physician for the user. To transition the day care from a long-stay model to a transitional one, only new users who expressed a desire to work would be accepted, and a system was established where the team psychiatrist performed gate control. Regular conferences involving research staff were also held to monitor support progress and maintain a system for quality control.

3. Outcomes of IPS Implementation

At the time of IPS implementation, the day care center had an average daily attendance of approximately 60 individuals (with half-day short-care users counted as 0.5 each) and received about 90 new annual requests for enrollment. From this pool, we achieved a stable number of 20-30 individuals per year securing competitive employment in general companies. This led to a shift in mindset among both staff and users, fostering the understanding that "daycare is a place to graduate from" and that "even users with severe mental disorders can work." Specifically, staff gained a deeper understanding of the importance and effectiveness of individualized support and outreach services, increasing efforts dedicated to these areas. Additionally, progress was made in securing employment and facilitating community transitions for long-term users who had been enrolled prior to day care reform.

Effectiveness verification through multi-facility collaborative research was also conducted. A randomized controlled trial demonstrated that employment support combining IPS-style supported employment with cognitive rehabilitation achieved approximately three times the employment rate and number of days worked compared with conventional employment support primarily focused on counseling.[15] Based on these results, the "Guidelines for Supported Employment in Collaboration with Medical Institutions, as Identified

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through Research,"[8] were developed and published.

II. Reasons for Discontinuing IPS at NCNP Hospital

As mentioned earlier, NCNP Day Care discontinued its IPS practice after eight years. The primary reason was the breakdown of the division of labor between daily living and employment support, which increased the staff members' workload. As participants' employment stabilized, the workload of the employment specialist (ES) decreased, while the burden on the case managers, who provide comprehensive daily living support, showed no notable reduction. ES who freed up capacity sought to support new participants one after another. This created a situation where Case Managers were expected to improve both the quality and quantity of daily living support. Furthermore, IPS operates on the principle of continuing support for as long as the need exists. Support cannot be terminated without the mutual consent of both the user and employer. This dynamic was further intensified when the number of ES increased from one to two after five years, leading to greater exhaustion among staff members responsible for case management.

The second reason is reduced revenue. Psychiatric day care is defined as group rehabilitation, and its medical fees are proportional to the number of attendees. Therefore, IPS, being fully individualized support, is a less profitable service to provide within a psychiatric day care setting. Furthermore, the very success of introducing IPS, where users graduate through employment or community transition, ultimately led to a decrease in day care attendees. Consequently, as shown in the figure, despite the total number of registered day care users not decreasing, the proportion of attendees using the service less than two days a week (equivalent to less than four half-day sessions per week) increased, causing medical fees to steadily decline.

The third reason is that the actual support deviated from the IPS principles. At the time, NCNP day care centers operated a system where support began when case managers enrolled users expressing a desire to work in the employment program. This employment program was primarily a group program focused on group work to share the meaning of employment, necessary mindset, and workplace etiquette. It was also one strategy to address the reality of job centers and companies demanding employment readiness. However, in practice, this resulted in inadequate employment support for users who found regular day care attendance difficult or who could not adapt to this group program. This

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contradicted the IPS principle of targeting all people with mental disabilities who desire employment. Furthermore, among those seeking employment, users with limited past work experience often struggled to envision their desired employment. Support for such users increasingly involved assigning them job openings developed by ES through supporter-led matching. This type of support diverged not only from IPS but also from the philosophy of recovery support.

Regarding these issues, the author, as the service provider in charge, notes that there were shortcomings in management. During participation in the multi-facility collaborative research, support was provided through research funding, and adherence to the research protocol meant that the research team also exerted a certain level of control over the support content. However, after the research concluded in fiscal year 2013, the expanded personnel became hospital employees, disrupting the financial balance. Furthermore, the leader was unable to correct the situation once the protocol-based oversight had been lifted.

III. The Need for and Challenges to Institutionalizing IPS

One characteristic of Japan's psychiatric care compared with advanced Western nations is the significant role played by private medical facilities. Furthermore, public hospitals are being successively converted into independent administrative agencies, necessitating greater attention to their financial management. Under these circumstances, psychiatric care, like other medical fields, utilizes the medical fee system as an incentive to implement national healthcare policies. In recent revisions to medical fees within the psychiatric field, while individual and outreach support systems have been emphasized, the effectiveness of group therapy, such as psychiatric day care, has increasingly been questioned. For example, attendance for day care users enrolled for more than a year is restricted to less than four days a week.

In IPS, medical care, daily living support, and even financial counseling are integrated and provided together with employment support, with employment specialists (ES) working collaboratively with a multidisciplinary mental health team. In Japan, recognition of ES as a distinct professional role is understandably poor. When introducing IPS, it is realistic to select personnel from within existing mental health teams to fulfill the ES role. In this regard, forming an IPS team within a medical institution can be considered an advantage. However, under the current medical fee system,

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there is no framework to secure sufficient reimbursement even when ES provides individualized support, including outreach to employers, beyond just the individual. When forced to utilize existing frameworks, introducing IPS into psychiatric day care programs is likely the option with the lowest barriers, as mentioned earlier. However, what occurred at the NCNP day care program could potentially happen at other day care facilities. The challenges for medical facilities to provide IPS as a sustainable service fundamentally concern securing revenue while maintaining service delivery aligned with the 8 principles or fidelity measures.

Fundamentally, in Japan, medical and disability welfare services are considered separate. There is no expectation that medical facilities providing healthcare services would also offer employment support, which is a disability welfare service. While the Ministry of Health, Labour and Welfare's "Project to Promote the Development of Community-Based Integrated Care Systems that Address Mental Disorders" includes multi-disciplinary outreach support as an item, its guidelines indicate that the activities of mental health teams remain strictly an extension of medical services.

So, how is IPS being implemented and disseminated within employment transition support centers, which serve as the foundation for providing employment support as a welfare service for persons with disabilities? The Ministry of Health, Labour and Welfare's website classifies disability welfare services into five categories: "visiting services," "day activity services," "facility-based services," "residential support services," and "training/employment services."[11] This suggests that employment support is fundamentally based on a facility-training model. Within disability welfare services, training and support aimed at employment in general companies are provided by "training/employment-based" employment transition support services. However, under the current system, remuneration is based on user attendance, making the remuneration framework essentially the same as that of psychiatric day care. The unit price of remuneration for a user's day of service can be increased by achieving high employment rates, which could be an advantage for introducing IPS. However, IPS, which emphasizes supporting users to secure employment as early as possible and prioritizes post-employment retention support, is at a disadvantage in terms of ensuring stable attendance numbers.

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Furthermore, under the current system, transition support centers do not receive remuneration for the initial six months of retention support after a user secures employment. Therefore, overall, the financial benefits of introducing IPS are limited. Additionally, challenges in implementing IPS include the basic two-year limit on service duration at employment transition support agencies, the difficulty in evaluating workplace development efforts, and occasional difficulties in coordinating with medical services.

As outlined above, even for IPS, whose effectiveness as EBP has been well established, institutionalized appropriate remuneration is essential to accelerate its dissemination and social implementation in Japan. The information necessary for remuneration is already available: who should receive support, what kind of support should be provided, what staffing is required, and how to evaluate the quality of support. The foreseeable barrier is the policy issue of where to position IPS, which straddles both medical and disability welfare services, within the remuneration system and which funding source to allocate. While utilizing healthcare funding sources seems appropriate in terms of scale, IPS is recognized as EBP solely for its employment support value, not as a medical practice. Furthermore, when viewed from the perspective of recovery support, the central actors in IPS are the team composed of the individual, employment specialist (ES), and case manager, not physician.

The challenge of institutionalizing IPS shares commonalities with Assertive Community Treatment (ACT), another EBP that remains uninstitutionalized. While ACT likely has greater affinity with medical services and more opportunities for utilization within medical reimbursement systems compared with IPS, the reality is that both support models currently require significant ingenuity and effort from implementing organizations to enhancing sustainability. Like ACT, institutionalizing IPS fundamentally involves positioning recovery support for people with mental illness within the broader social system.

Conclusion

This paper outlines the difficulty of maintaining the quality of support while securing revenue in the continuous practice of IPS under the current medical and welfare system, citing an example from NCNP. IPS, an employment support program integrated with medical and daily living assistance, is an important and essential component of recovery support for individuals with severe mental

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illness, alongside ACT. It is hoped that the efforts and achievements of pioneers, motivated by a passion to deliver good practice to people with mental disorders, will promote societal demand and serve as a major driving force in overcoming challenges toward institutionalization.

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There are no conflicts of interest to disclose regarding this paper.

References

1) Becker, D. R., Drake, R. E.: A Working Life for People with Severe Mental Illness: Innovations in Practice and Service Delivery with Vulnerable Populations. Oxford University Press, New York, 2003

2) Bond, G. R., Drake, R. E., Becker, D. R.: Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US. World Psychiatry, 11 (1); 32-39, 2012

3) Bond, G. R., Peterson, A. E., Becker, D. R., et al.: Validation of the Revised Individual Placement and Support Fidelity Scale (IPS-25). Psychiatr Serv, 63 (8); 758-763, 2012

4) de Winter, L., Couwenbergh, C., van Weeghel, J., et al.: Who benefits from individual placement and support? A meta-analysis. Epidemiol Psychiatr Sci, 31; e50, 2022

5) Drake, R. E., Becker, D. R., Bond, G. R.: Introducing Individual Placement and Support (IPS) supported employment in Japan. Psychiatry Clin Neurosci, 73 (2); 47-49, 2019

6) Frederick, D. E., VanderWeele, T. J.: Supported employment: meta-analysis and review of randomized controlled trials of individual placement and support. PLoS One, 14 (2); e0212208, 2019

7) Hellström, L., Pedersen, P., Christensen, T. N., et al.: Vocational outcomes of the individual placement and support model in subgroups of diagnoses, substance abuse, and forensic conditions: a systematic review and analysis of pooled original data. J Occup Rehabil, 31 (4); 699-710, 2021

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8) 伊藤順一郎編・監: 研究から見えてきた, 医療機関と連携した援助付き雇用の支援のガイドライン. 国立精神・神経医療研究センター精神保健研究所社会復帰研究部, 2015 (https:/www.ncnp.go.jp/nimh/chiiki/documents/vs170817.pdf) (参照 2023-06-16) (in Japanese)

9) Kinoshita, Y., Furukawa, T. A., Kinoshita, K., et al.: Supported employment for adults with severe mental illness. Cochrane Database Syst Rev, 2013 (9); CD008297, 2013

10) 厚生労働科学研究費補助金〔難病・がん等の疾患分野の医療の実用化研究(精神疾患関係研究分野)〕「『地域生活中心』を推進する, 地域精神科医療モデル作りとその効果検証に関する研究」平成 25 年度総括・研究分担報告書(研究代表者: 伊藤順一郎). 2014 (in Japanese)

11) 厚生労働省: 障害福祉サービスについて. (https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/hukushi_kaigo/shougaishahukushi/service/naiyou.html) (参照 2023–07–04) (in Japanese)

12) Modini, M., Tan, L., Brinchmann, B., et al.: Supported employment for people with severe mental illness: systematic review and meta-analysis of the international evidence. Br J Psychiatry, 209 (1); 14-22, 2016

13) Sasaki, N., Yamaguchi, S., Shimodaira, M., et al.: Development and validation of a Japanese fidelity scale for supported employment. Adm Policy Ment Health, 45 (2); 318-327, 2018

14) Suijkerbuijk, Y. B., Schaafsma, F. G., van Mechelen, J. C., et al.: Interventions for obtaining and maintaining employment in adults with severe mental illness, a network meta-analysis. Cochrane Database Syst Rev, 9 (9); CD011867, 2017

15) Yamaguchi, S., Sato, S., Horio, N., et al.: Cost-effectiveness of cognitive remediation and supported employment for people with mental illness: a randomized controlled trial. Psychol Med, 47 (1); 53-65, 2017

16) Yamaguchi, S., Sato, S., Ojio, Y., et al.: Assessing stable validity and reliability of the Japanese version of the individualized supported employment fidelity scale: a replication. Neuropsychopharmacol Rep, 41 (2); 248-254, 2021

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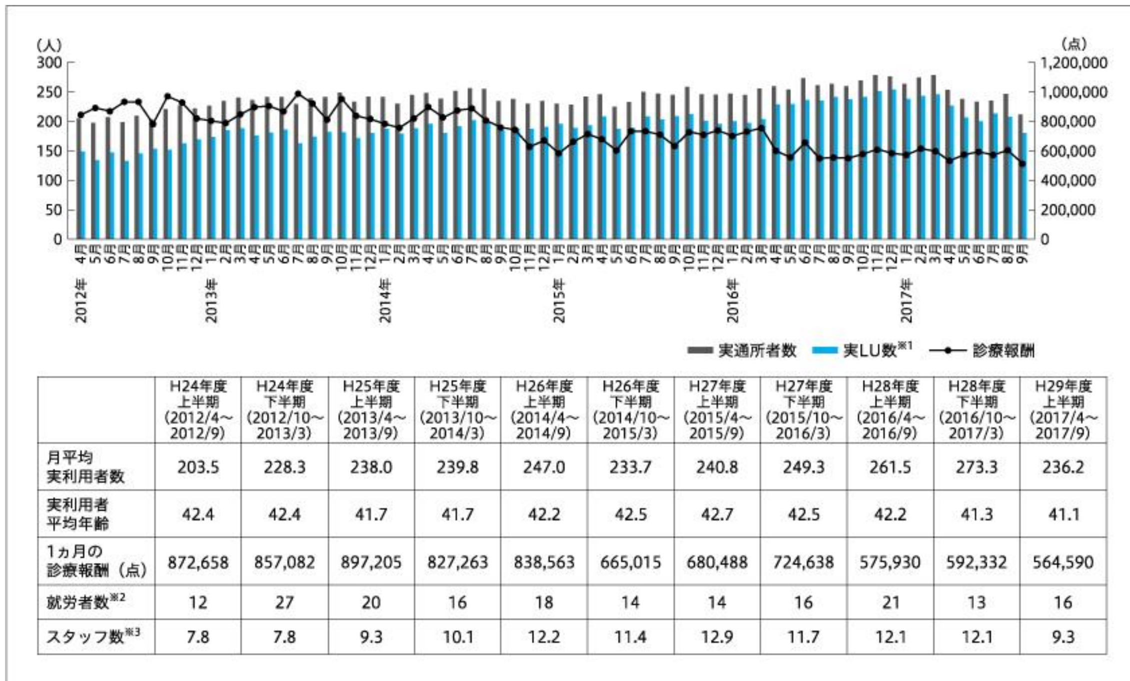

	H24年度 上半期 (2012/4～2012/9)	H24年度 下半期 (2012/10～2013/3)	H25年度 上半期 (2013/4～2013/9)	H25年度 下半期 (2013/10～2014/3)	H26年度 上半期 (2014/4～2014/9)	H26年度 下半期 (2014/10～2015/3)	H27年度 上半期 (2015/4～2015/9)	H27年度 下半期 (2015/10～2016/3)	H28年度 上半期 (2016/4～2016/9)	H28年度 下半期 (2016/10～2017/3)	H29年度 上半期 (2017/4～2017/9)
月平均 実利用者数	203.5	228.3	238.0	239.8	247.0	233.7	240.8	249.3	261.5	273.3	236.2
実利用者 平均年齢	42.4	42.4	41.7	41.7	42.2	42.5	42.7	42.5	42.2	41.3	41.1
1ヵ月の 診療報酬（点）	872,658	857,082	897,205	827,263	838,563	665,015	680,488	724,638	575,930	592,332	564,590
就労者数※2	12	27	20	16	18	14	14	16	21	13	16
スタッフ数※3	7.8	7.8	9.3	10.1	12.2	11.4	12.9	11.7	12.1	12.1	9.3

図　NCNP 病院デイケアにおける就労支援開始後の利用者数ほかの推移

※1 LU（light users）は，半日利用を 1 コマとして，週 4 コマの利用に満たない利用者
※2 新規就労者および復職者の合計
※3 常勤換算値（スタッフ全員の 1 週間の合計勤務時間を 37.5 で除した値）

Figure: Trends in the number of users and related indicators following the introduction of employment support at NCNP Hospital Day Care

*1 LU (light users) refers to individuals who attend less than four sessions per week, with one session corresponding to half-day use.
*2 Total number of new employees and individuals returning to work.
*3 Full-time equivalent (FTE) value, calculated by dividing the total weekly working hours of all staff by 37.5.

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