practice wisdom[8] and for experiential knowledge.

A second implication is that clinical explanatory frameworks are not universal. Alternative explanatory frameworks exist, and it is simply not possible to know whether it is ultimately more beneficial to a person to frame his/her experience as, for example, a spiritual crisis, a trauma-related response, or an illness relapse. This is challenging, since some people experiencing mental health-related crisis actively want "psychiatric rescue", i.e. an authoritative institutionalized response which temporarily takes decisions on behalf of the person in order to restore stability.

However, the phenomenon of revolving door and the challenges of improving long-term outcomes in psychosis indicate the limits of any single explanatory framework. Therefore, any clinical explanation for experiences should be offered with tentativeness rather than authority, and clinicians might usefully sign-post service users towards alternative perspectives, such as Alternatives To Suicide, Hearing Voices Network, Mad Pride, positive psychotherapy for psychosis, post-traumatic growth, spiritual emergence, and trauma-informed approaches.

More challengingly, a focus on the experience of social exclusion may generate momentum away from individual-level explanations of experience and towards activities to generate collective action to improve mental health and social care system compliance with human rights legislation[9]. Modesty in clinical knowledge claims is empirically justified.

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An update on Individual Placement and Support

Disability experts and public officials in countries around the world now acknowledge that people with chronic health conditions and disabilities, including serious mental illnesses, have a right to participate fully in community life, including regular employment. Employment is not only a determinant of health and well-being, including mental health[1], but also an antidote to social exclusion[2].

Individual Placement and Support (IPS) has become the standard of supported employment for people with serious mental illness, such as schizophrenia and bipolar disorder. It incorporates eight core principles that have been well researched with a validated fidelity scale used worldwide for quality improvement purposes[3].

These principles are: a) focus on the goal of competitive employment (agencies providing IPS are committed to regular jobs in the community as an attainable goal for clients seeking employment); b) zero exclusion (every client who wants to work is eligible for services regardless of "readiness", work experience, symptoms, or any other issue); c) attention to clients' preferences (services align with clients' choices, rather than practitioners' expertise or judgments; IPS specialists help clients find jobs that fit their preferences and skills); d) rapid job search (IPS programs help a client look for jobs soon after he/she expresses interest in working, rather than providing lengthy pre-employment assessment, training and counseling); e) targeted job development (based on clients' interests, IPS specialists build relationships with employers through repeated contact, learning about the business needs of employers, and introducing employers to qualified job seekers); f) integration of employment services with mental health treatment (IPS programs closely integrate with mental health treatment teams); g) personalized benefits counseling (IPS specialists help clients obtain personalized, understandable and accurate information about how working may impact their disability insurance and other government entitlements); h) individualized long-term support (follow-along supports, tailored for the individual, continue for as long as the client wants and needs them to keep a job or advance career opportunities).

Evidence for the effectiveness of IPS continues to grow, starting with early studies in the US in the 1990s and 2000s and extending to replication studies throughout Europe, Canada, Australia, Hong Kong and Japan. IPS is the most extensively and rigorously researched of all employment models and the only evidence-based employment model for people with serious mental illness.

In 28 randomized controlled trials assessing the effectiveness of IPS for people with serious mental illness, all but one in mainland China found competitive employment outcomes significantly favoring IPS. Across the 28 studies (N=6,468), 55% of IPS participants achieved competitive employment, compared to 25% of control participants receiving other vocational services (https://ipsworks.org/index.php/evidence-for-ips/).

Over the last decade, a number of systematic reviews and meta-analyses have confirmed this basic finding[4,5]. One meta-analysis reported moderate to large effects favoring IPS for a range of other employment outcomes[5]. Another meta-analysis found that, compared to control participants, IPS participants gained employment faster, maintained employment four times longer during follow-up, earned three times the amount from employment, and were three times as likely to work 20 hours or more per week (https://ipsworks.org/index.php/evidence-for-ips/).

Long-term studies show that half of all clients enrolled in IPS become steady workers, maintaining employment for 10 years or

longer. A recent follow-up study of a large, multisite trial found that significantly higher earnings for IPS clients compared to controls persisted over a five-year period after the two-year intervention[6]. Cost-effectiveness analyses of randomized controlled trials of IPS have generally found the aggregated costs of vocational and mental health services to be no higher, and sometimes significantly lower, for IPS than for standard services[2].

IPS has expanded steadily, spreading to new clinical populations and more mental health settings in the US and worldwide. Recent randomized controlled trials of IPS include six trials for people with common mental disorders, two for people with substance use disorders, and one for veterans with spinal cord injuries. Eight of these nine studies showed employment outcomes significantly favoring IPS[7].

Several large-scale IPS trials in other populations are in progress, including three for people with substance use disorders: Project BEES in the US, the IPS-AD study in the UK, and a similar study in Norway. Several small randomized controlled trials of IPS for people with criminal justice involvement have been completed, with a large-scale US trial, the Next Gen study, to start soon. Following pilot work, large IPS trials are planned or underway for people with autism spectrum disorder, borderline personality disorder, and chronic pain.

IPS also helps young adults negotiate the pathway to meaningful adult roles in employment and education, e.g., as a standard component of early intervention programs for clients with a first episode of psychosis. Other subgroups of the young adult population also appear to benefit from IPS (https://ipsworks.org/index.php/evidence-for-ips/).

The effectiveness of IPS has been well established since at least the turn of the century. The key question for IPS, as for other evidence-based psychosocial practices, is how to close the gap between the known population of those who want and need these evidence-based services and those who have access. In the US, approximately 60% of people with serious mental illness want to work, but less than 2% have access to IPS. The primary barriers have been inadequate funding and the lack of methodology for large-scale expansion[2].

While adequate financing remains elusive worldwide, some governments have made national commitments to fund IPS access[8]. The second ingredient is a mechanism to facilitate adoption, high-fidelity implementation, growth and sustainment of IPS. Since 2002, our group has led an international learning community that coordinates education, training, technical assistance, fidelity and outcome monitoring, and regular communications through newsletters, bimonthly calls, and an annual meeting[9].

The learning community has continuously reported employment rates for participating IPS programs in the US every three months for 18 years. During this time, the overall quarterly employment rate has not dipped below 40%, even during the Great Recession. The learning community helps programs sustain IPS services over time: in one prospective study, 96% of 129 IPS programs were sustained over two years. Participation has expanded steadily, with a mean annual growth rate of 26% in the number of IPS programs in the US. The learning community helps to maintain over 450 IPS programs, including 366 in the US and 100 outside the US, most at high fidelity with good employment outcomes.

Rapid expansion of IPS across the world[8] includes at least 19 high-income countries outside the US over the past 20 years (Australia, Belgium, Canada, China, Czech Republic, Denmark, France, Germany, Iceland, Ireland, Italy, Japan, New Zealand, the Netherlands, Norway, Spain, Sweden, Switzerland, and the UK). The flexibility and adaptability of the IPS model facilitate successful adoption with high fidelity and good employment outcomes in countries with diverse sociocultural conditions, labor laws, welfare systems, and economic conditions[4].

The steady growth of programs, sustainment of services, and expansion to new populations makes IPS a unique evidence-based practice. We attribute success to client interest, continuous research-based improvements, and a vibrant learning community.

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Delivering on the public health promise of the psychosis risk paradigm

The clinical high-risk (CHR) paradigm was developed in the 1990s as a framework for early detection and prevention of psychotic disorders[1]. Now, after about 25 years of experience, it seems opportune to reconsider the goals of the paradigm in relation to its aspired impacts on public health. In particular, it is reasonable to question whether the focus on conversion to a fully psychotic form of illness as the singular endpoint of interest is well-placed.

Although many *research* goals have been advanced using this endpoint, including the development and validation of individualized risk calculators[2] and the identification of neural mechanisms associated with the onset of psychosis[3], the *clinical* impacts of these advances are at present limited.